Rocky Mountain Medical Journal

January
1955

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Table of Contents

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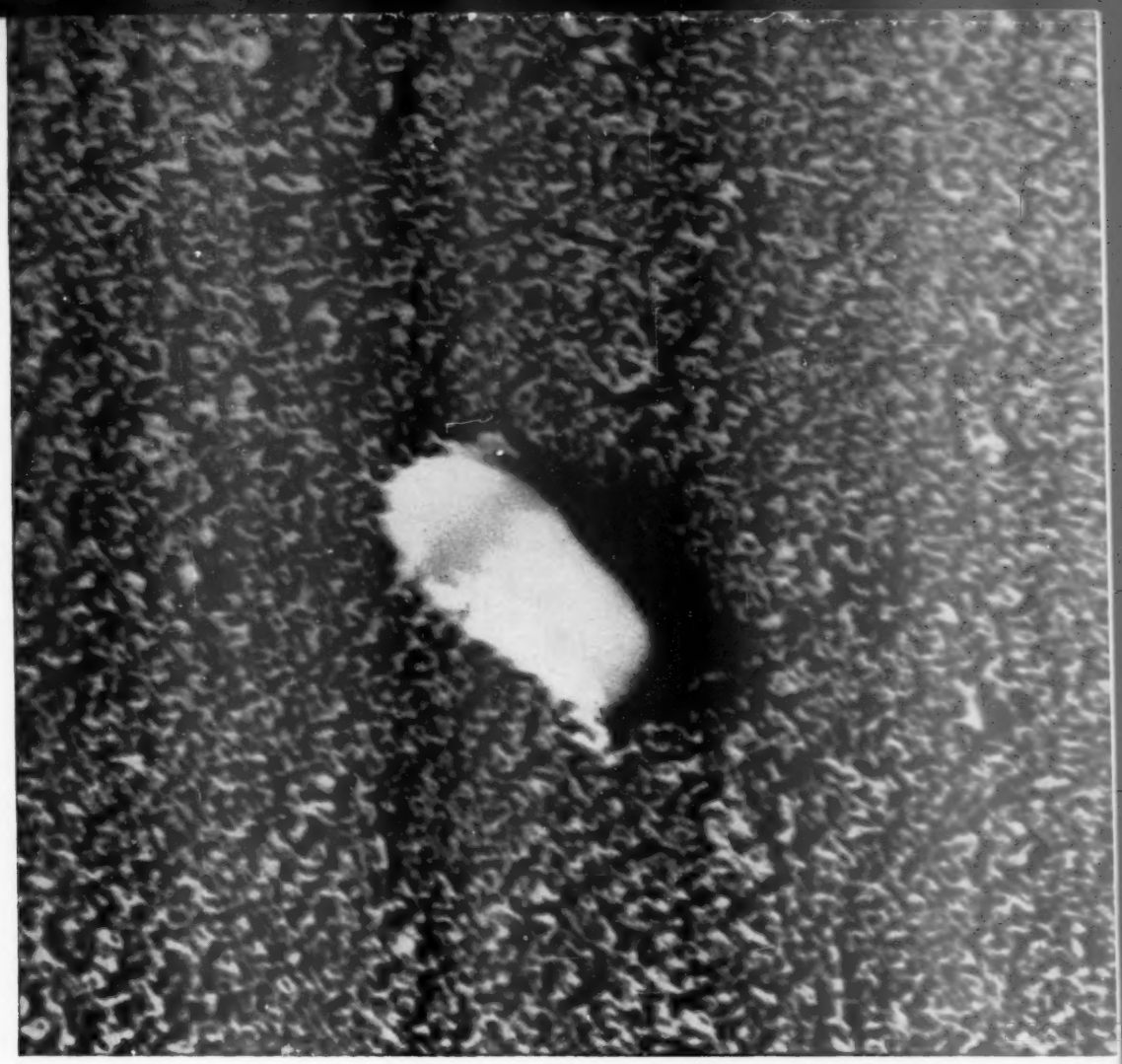

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NEXT ANNUAL SESSION: SEPTEMBER 20-23, 1955; SHIRLEY-SAVOY HOTEL, DENVER

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Meat...

in Geriatric Nutrition

Although the nutrient needs for optimal health in the aged are not known to differ significantly from those in younger adults,[1] it has been shown that the daily protein requirements in elderly patients vary from person to person. Ascertained values range from below to above allowances recommended for persons in earlier years of adulthood.[2]

According to criteria such as "physical activity, gastrointestinal structure and function, pathologic disturbances, and chemical balances," it is suggested that an optimal diet for the elderly patient should provide at least 20 per cent of its calories in the form of protein.[3]

For several reasons this high intake of protein appears desirable. Decreased activity in the aged tends to induce loss of tissue protein. Preservation of protein enzymes and of endocrinal harmony necessary for supporting anabolic processes requires adequate protein nutrition. Also, the aged person usually is able to handle the end products of protein metabolism satisfactorily.

Generous amounts of tender lean meat can go a long way in supplying the needs of the aged for top quality protein. From 25 to 30 per cent or more of cooked lean meat is protein. Other valuable contributions include the B group of vitamins and essential minerals, especially iron, phosphorus, and potassium. The easy and almost complete digestibility and the palate appeal of meat constitute physiologic values important in the nutrition of the geriatric patient.

---

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The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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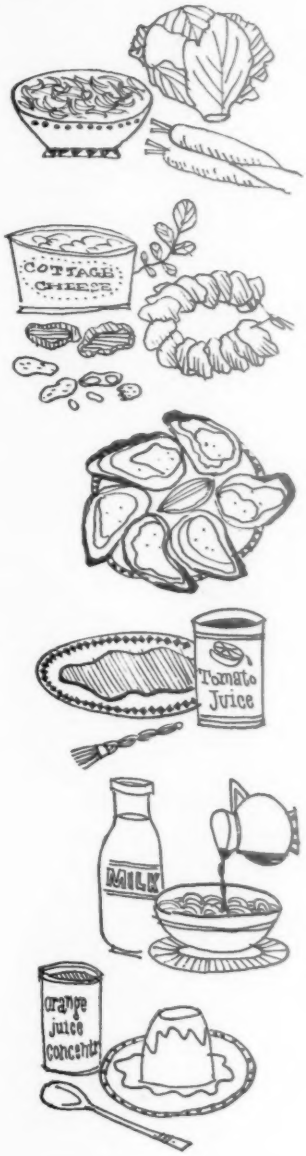

Foods high in vitamins and minerals not only give your patient good nutrition naturally, but also may supply vital elements still unknown. These "diet do's" may tempt him to rely more on food than supplements for his vital nutrients.

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Custard contains calcium and vitamins A, B_1, and B_2. A topping of orange juice concentrate gives your patient a bonus in vitamin C.

Although these "do's" list only the more familiar vitamins and minerals, the trace elements and other micronutrients are no less important. And a varied diet will help your patient get the vital body regulators he needs.

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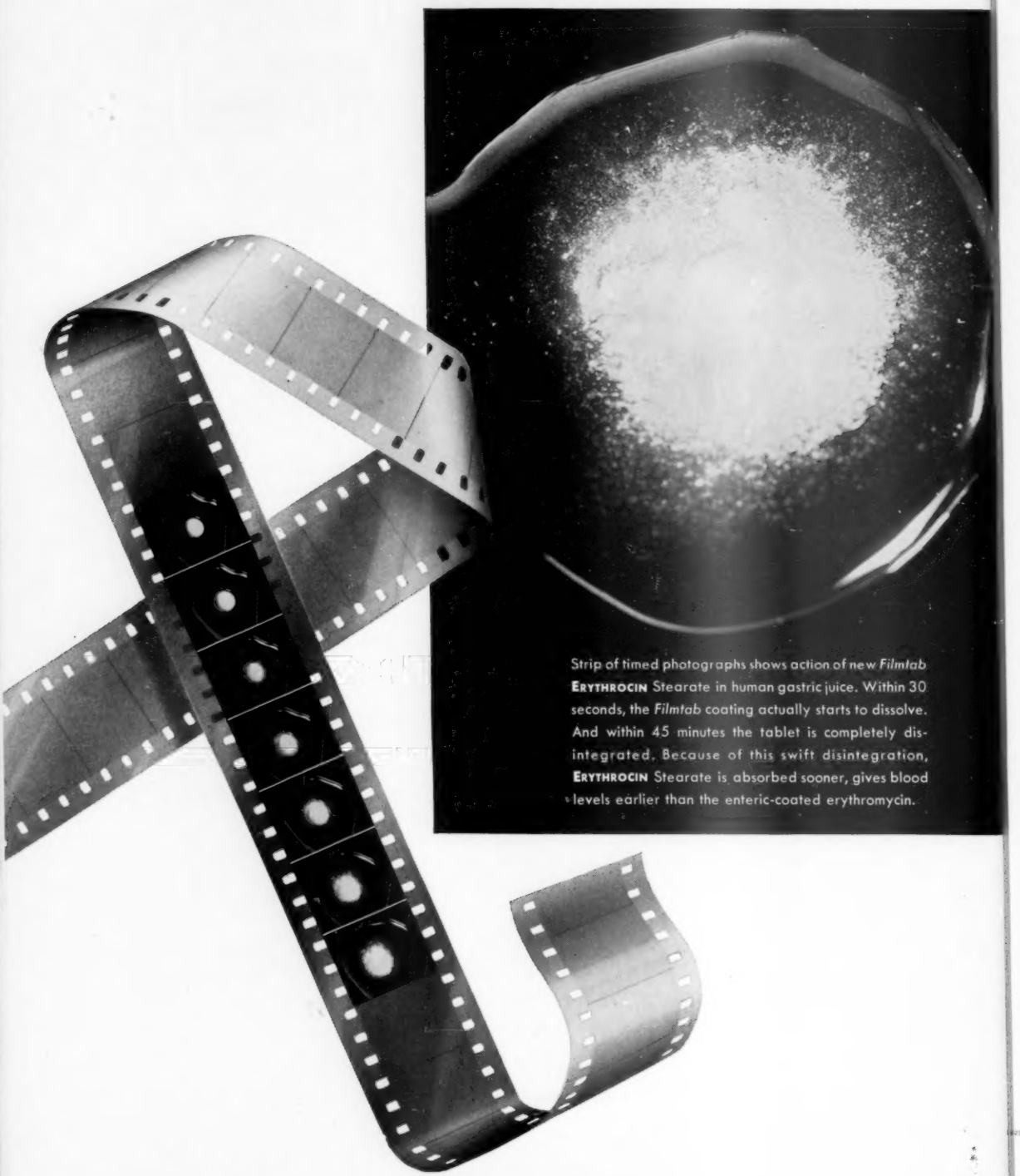

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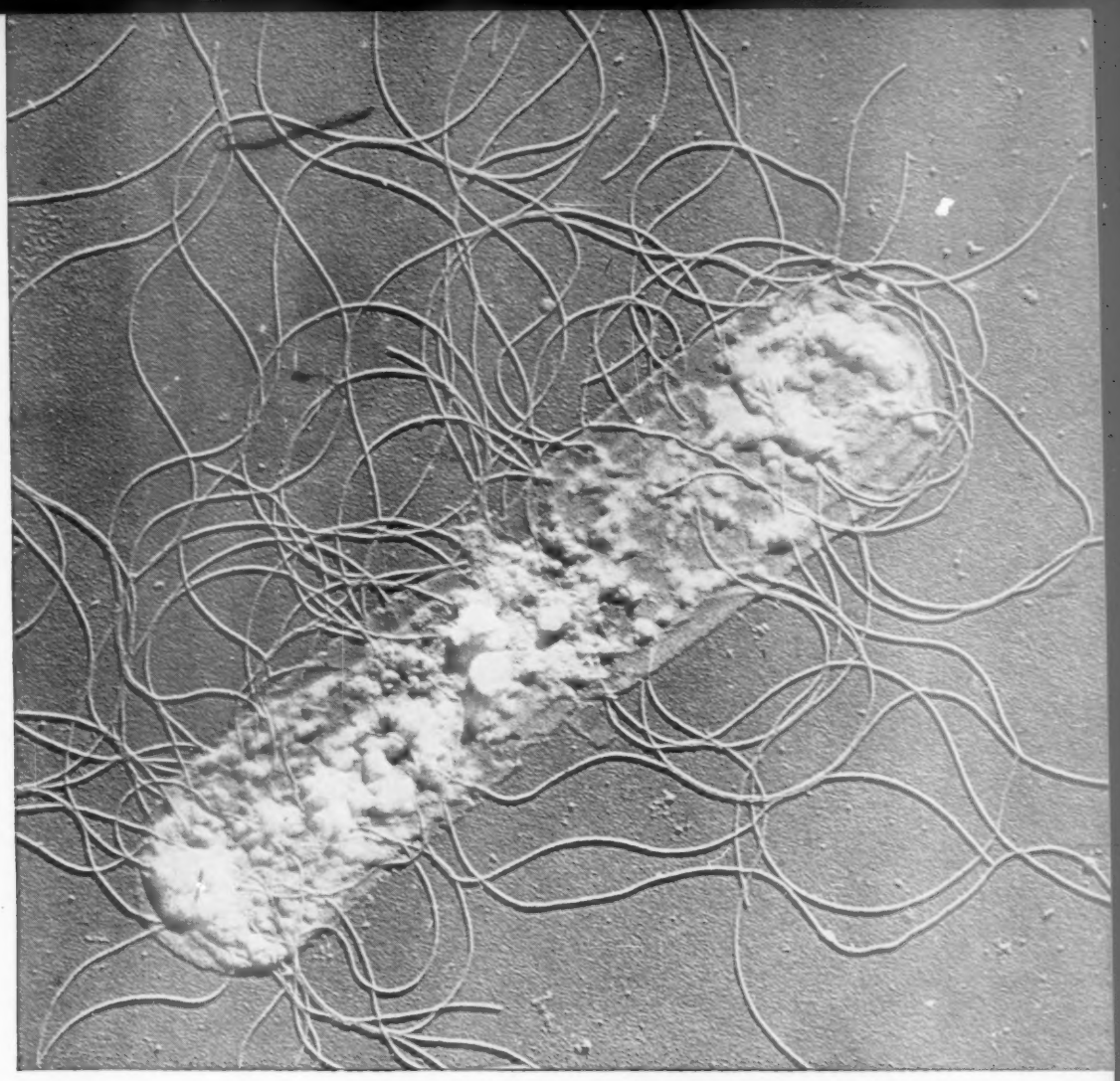

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Rocky Mountain Medical Journal

JANUARY, 1955

Colorado - Montana - New Mexico
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Buried Prosthesis in Soft Tissue Surgery

SOME substance suitable for tissue replacement in contour defects of the human body has long been sought. Depressions, particularly about the face, often constitute major catastrophes from the patient's standpoint. Problems of this type have increased with crushing blows incidental to our age of speed—and human vanity remains unchanged. Thus, there exists a lucrative field ripe for exploitation by the quack or for research by sincere workers and astute observers.

Many materials have been used, the most notorious having been paraffin. Unhappy patients with progressive deformity from paraffinoma attest its fallacy and danger. These tumors are most commonly noted in cheeks, noses, chins, neck, and even the backs of hands. The original foreign body has usually lost its identity and the site has become invaded by fibrous tissue and blood vessels; deformity is progressive, often grotesque. Surgery is difficult and unsatisfactory; malignant changes have been reported. Unfortunately this unsavory history has not entirely deterred the quack and other substances, equally obnoxious, have been used. Beeswax and vaseline, oil, and unknown concoctions are noted. But all the foreign material has not been used by charlatans. Ivory had its inning in the hands of reputable members of our profession. Some of the material was retained up to twenty years, perhaps more, before inevitable foreign body reaction and expulsion.

We must not overlook the fact that we all use and bury foreign material—catgut, cotton, silk, tantalum, stainless steel, screws, plates. Maybe guilt is only a matter of degree! We may be sure that the smaller the foreign body, the less likely it will be heard from; the more vascular the recipient bed, the kinder and longer its tolerance; any degree of infection will probably result in prompt expulsion. There is a dangerous "modern" vogue now on the market—voluptuousness, at any cost or hazard. Conceived in Hollywood, nurtured in N. Y. C., publicized by the press, furthered by the unscrupulous and maintained by sex-consciousness of human beings, the scourge afflicts hopeful and unwary individuals.

The world's goods are ill-distributed—too much here, not enough there. One patient will say she'd give anything to remove and hang her heavy pendulous breasts over the foot of the bed at night; another will brood over inadequate pulchritudinous eminences. Relief for the former is relatively safe; but for the latter it is fraught with risk as it entails extraneous material. Most recent among such substances is Ivalon, a spongy polymer of polyvinyl alcohol with formaldehyde. Its advocates claim that it acts as a framework for living tissue, but admit it is an "excellent culture medium" difficult if not impossible to save if once infected. Among its advantages are claimed no sharp margins; no absorption; easily shaped; no complicated surgery to

procure it, as in use of autogenous tissue. Furthermore, say the authors, "We strongly urge against promiscuous use of prothesis to build up small breasts and that it never be used in cases with family history of breast cancer."

How important is family history in breast cancer? If an unpredictable substance should not be used in any case, should it be used at all? Particularly in elective treatment of harmless conditions! If contour defects, large or small, unilateral or bilateral, threaten to precipitate a psychosis, introduction of an unpredictable substance and creation of a scar may merely postpone or alter its type or degree. Let us always ask ourselves the question, "Would I recommend or accept this operation upon my wife or daughter?"

Polio In Our Area

THE polio attack rate in the Rocky Mountain States in the year just concluded was significantly higher for each of the five states than the national average, according to preliminary reports. Nationwide the number of polio cases reported in 1954 was the third highest on record.

The polio attack rate in Wyoming was 260 per cent higher than the national average; in Utah about 50 per cent higher; in New Mexico about 25 per cent higher; in Colorado and Montana about 15 per cent higher.

The Rocky Mountain States also had high polio attack rates in the years 1951 and 1952. In 1951 Wyoming's attack rate, with 213 polio cases reported, was nearly three times higher than the national average; Utah's attack rate that year, with 585 polio cases reported, was close to three and one-half times higher than the national average. Colorado, with 1,065 cases reported, also had an attack rate over three times higher than the national average.

In 1952, which was the high record year for total number of polio cases reported in the U. S., the polio attack rate in New Mexico, with 502 cases reported, was 83 per cent higher than the national average that year; in Nevada, with 108 cases reported, 58 per cent higher; and in Montana, with 260 cases reported, 17 per cent higher.

Evaluation of the Salk vaccine, administered to 440,000 U. S. children, in the largest medical experiment of its kind ever conducted, is now in progress.

Thousands of children in the Rocky Mountain states participated in the 1954 Polio Vaccine Field Trials. In Utah, about 25,000 children were inoculated, half with the Salk vaccine, half with a placebo. In Montana about 3,200 children were similarly inoculated, half with vaccine, half with placebo. In Colorado about 14,000 children, in New Mexico about 3,300 children, in Wyoming about 1,400 children received injections of the Salk vaccine.

It is hoped that Rocky Mountain States' physicians will support the 1955 March of Dimes as enthusiastically as approximately 20,000 physicians throughout the United States cooperated in the 1954 vaccine field trials sponsored by the National Foundation for Infantile Paralysis.

—Contributed.

Changing Doctors

APPARENTLY there is a belief among patients that some sort of law forbids them to change doctors. The impression has been abetted by physicians turning down calls, particularly at night, because "You are Dr. So-and-So's patient." This, seemingly without explanation, is hurting our public relations! Patients are often frank enough to mention their previous doctor, and may state reasons for dissatisfaction. Let us be equally frank. Certainly they should be told that free choice of physician is one of their privileges. Their ethical obligation, however, is that the previous physician shall be dismissed or apprised of their decision. After this courtesy, they are at liberty to choose again. Our friendly understanding and best efforts should invariably follow. Otherwise an insult is added to injury, and good will is further impaired.

At all times, day or night, let us remember that patients behave like people—and may we practice according to the Golden Rule!

Spontaneous Rupture of the Esophagus: A Surgical Emergency*

MORDANT E. PECK, M.D., AND EDWARD B. LIDDLE, JR., M.D.
Denver

SPONTANEOUS rupture of the esophagus is a surgical emergency that has not been commonly recognized. However, it is one which is now being diagnosed with increasing frequency because we are becoming aware of its causative factors and its symptomatology. As a corollary, we are treating it with increased success.

The first antemortem diagnosis was reported in 1924 by Walker[1]. Subsequently, there were no survivors among some fifty recorded cases until, in 1947, the English surgeon, Barrett, described the first successfully operated patient[2]†. In 1952, Anderson was able to collect from the literature a total of 104 cases with twenty-six survivals, eight of whom were reported in 1951[3]. The American literature, in 1952 and 1953, contains reports of twenty-two more cases, of whom eighteen survived, all but one of these survivals associated with operation. (Table I).

TABLE I
Cases of Spontaneous Rupture of the Esophagus Reported in 1952 and 1953

Author (and Ref. No.)	No. of Cases	No. of Survivals	Remarks
1. Anderson[3]	4	4	
2. In discussion of Anderson's paper:			
a. Heroy	2	2	
b. Overholt	1	1	
c. Waterman	6	5	
d. Seley	1	1	not operated
3. Bugden[4]	1	1	
4. Ware, Shnider and Davis[5]	1	1	
5. Mackler[6]	3	2	
6. Muendel and Levison[7]	1	0	
7. Alt, Bixby and Rowell[8]	2	1	
Totals	22	18	

The symptomatology, diagnosis and treatment of this condition have been reviewed, confirmed and emphasized by several authors within the past two to three years. These men have all described spontaneous rupture of the esophagus as typically occuring in the middle-aged male who has recently been eating or drinking excessively. He may become nauseated and will then vomit or retch, following which he will suddenly develop exquisite epigastric and substernal pain, very shortly associated with dyspnea, cyanosis and circulatory collapse. Physical examination may reveal hydrothorax or hydropneumothorax, usually on the left side, subcutaneous emphysema in the neck or chest wall, and a rigid, but nontender, upper abdomen. Many of these patients have histories of previous gastrointestinal upsets suggestive of peptic ulcer.

The diagnosis is made clinically by the triad of vomiting followed by the characteristic pain, dyspnea and the subcutaneous emphysema. If a hydrothorax is present, aspiration of the fluid will reveal particles of food and sometimes acid. X-ray demonstration of emphysema in the mediastinum or neck or both, and later of hydrothorax or hydropneumothorax is almost confirmatory. X-ray diagnosis may be obtained by demonstrating an extravasation of radio-opaque medium (preferably lipiodal) into the mediastinum or chest.

*Read before the 84th Annual Meeting of the Colorado State Medical Society, Colorado Springs, Colorado, September 24, 1954. From the Department of Surgery, Division of Thoracic Surgery, University of Colorado School of Medicine, Denver, Colorado.

†Note: Evarts Graham, in an Editor's Note to a reviewed article in the 1944 Year Book of Surgery, made reference, without actual report, to two cases he had successfully treated by drainage of the associated empyema.

procure it, as in use of autogenous tissue. Furthermore, say the authors, "We strongly urge against promiscuous use of prothesis to build up small breasts and that it never be used in cases with family history of breast cancer."

How important is family history in breast cancer? If an unpredictable substance should not be used in any case, should it be used at all? Particularly in elective treatment of harmless conditions! If contour defects, large or small, unilateral or bilateral, threaten to precipitate a psychosis, introduction of an unpredictable substance and creation of a scar may merely postpone or alter its type or degree. Let us always ask ourselves the question, "Would I recommend or accept this operation upon my wife or daughter?"

Polio In Our Area

THE polio attack rate in the Rocky Mountain States in the year just concluded was significantly higher for each of the five states than the national average, according to preliminary reports. Nationwide the number of polio cases reported in 1954 was the third highest on record.

The polio attack rate in Wyoming was 260 per cent higher than the national average; in Utah about 50 per cent higher; in New Mexico about 25 per cent higher; in Colorado and Montana about 15 per cent higher.

The Rocky Mountain States also had high polio attack rates in the years 1951 and 1952. In 1951 Wyoming's attack rate, with 213 polio cases reported, was nearly three times higher than the national average; Utah's attack rate that year, with 585 polio cases reported, was close to three and one-half times higher than the national average. Colorado, with 1,065 cases reported, also had an attack rate over three times higher than the national average.

In 1952, which was the high record year for total number of polio cases reported in the U. S., the polio attack rate in New Mexico, with 502 cases reported, was 83 per cent higher than the national average that year; in Nevada, with 108 cases reported, 58 per cent higher; and in Montana, with 260 cases reported, 17 per cent higher.

Evaluation of the Salk vaccine, administered to 440,000 U. S. children, in the largest medical experiment of its kind ever conducted, is now in progress.

Thousands of children in the Rocky Mountain states participated in the 1954 Polio Vaccine Field Trials. In Utah, about 25,000 children were inoculated, half with the Salk vaccine, half with a placebo. In Montana about 3,200 children were similarly inoculated, half with vaccine, half with placebo. In Colorado about 14,000 children, in New Mexico about 3,300 children, in Wyoming about 1,400 children received injections of the Salk vaccine.

It is hoped that Rocky Mountain States' physicians will support the 1955 March of Dimes as enthusiastically as approximately 20,000 physicians throughout the United States cooperated in the 1954 vaccine field trials sponsored by the National Foundation for Infantile Paralysis.

—Contributed.

Changing Doctors

APPARENTLY there is a belief among patients that some sort of law forbids them to change doctors. The impression has been abetted by physicians turning down calls, particularly at night, because "You are Dr. So-and-So's patient." This, seemingly without explanation, is hurting our public relations! Patients are often frank enough to mention their previous doctor, and may state reasons for dissatisfaction. Let us be equally frank. Certainly they should be told that free choice of physician is one of their privileges. Their ethical obligation, however, is that the previous physician shall be dismissed or apprised of their decision. After this courtesy, they are at liberty to choose again. Our friendly understanding and best efforts should invariably follow. Otherwise an insult is added to injury, and good will is further impaired.

At all times, day or night, let us remember that patients behave like people—and may we practice according to the Golden Rule!

Spontaneous Rupture of the Esophagus: A Surgical Emergency*

MORDANT E. PECK, M.D., AND EDWARD B. LIDDLE, JR., M.D.
Denver

SPONTANEOUS rupture of the esophagus is a surgical emergency that has not been commonly recognized. However, it is one which is now being diagnosed with increasing frequency because we are becoming aware of its causative factors and its symptomatology. As a corollary, we are treating it with increased success.

The first antemortem diagnosis was reported in 1924 by Walker[1]. Subsequently, there were no survivors among some fifty recorded cases until, in 1947, the English surgeon, Barrett, described the first successfully operated patient[2]†. In 1952, Anderson was able to collect from the literature a total of 104 cases with twenty-six survivals, eight of whom were reported in 1951[3]. The American literature, in 1952 and 1953, contains reports of twenty-two more cases, of whom eighteen survived, all but one of these survivals associated with operation. (Table I).

TABLE I
Cases of Spontaneous Rupture of the Esophagus Reported in 1952 and 1953

Author (and Ref. No.)	No. of Cases	No. of Survivals	Remarks
1. Anderson[3]	4	4	
2. In discussion of Anderson's paper:			
a. Heroy	2	2	
b. Overholt	1	1	
c. Waterman	6	5	
d. Seley	1	1	not operated
3. Bugden[4]	1	1	
4. Ware, Shnider and Davis[5]	1	1	
5. Mackler[6]	3	2	
6. Muendel and Levison[7]	1	0	
7. Alt, Bixby and Rowell[8]	2	1	
Totals	22	18	

The symptomatology, diagnosis and treatment of this condition have been reviewed, confirmed and emphasized by several authors within the past two to three years. These men have all described spontaneous rupture of the esophagus as typically occuring in the middle-aged male who has recently been eating or drinking excessively. He may become nauseated and will then vomit or retch, following which he will suddenly develop exquisite epigastric and substernal pain, very shortly associated with dyspnea, cyanosis and circulatory collapse. Physical examination may reveal hydrothorax or hydropneumothorax, usually on the left side, subcutaneous emphysema in the neck or chest wall, and a rigid, but nontender, upper abdomen. Many of these patients have histories of previous gastrointestinal upsets suggestive of peptic ulcer.

The diagnosis is made clinically by the triad of vomiting followed by the characteristic pain, dyspnea and the subcutaneous emphysema. If a hydrothorax is present, aspiration of the fluid will reveal particles of food and sometimes acid. X-ray demonstration of emphysema in the mediastinum or neck or both, and later of hydrothorax or hydropneumothorax is almost confirmatory. X-ray diagnosis may be obtained by demonstrating an extravasation of radio-opaque medium (preferably lipiodal) into the mediastinum or chest.

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The only definitive treatment which can be offered to such a patient is early thoracotomy with transpleural repair of the rupture and drainage of the mediastinum and pleural cavity. Intensive antibiotic therapy and careful supportive care are, of course, necessary. It is important to realize that early operation, in itself, is one of the most effective resuscitative measures in this condition, and should not be unduly delayed. If the diagnosis is not made initially, the majority of the patients will die; if the patient survives the acute crisis, such complications as esophagopleural fistula or empyema invariably develop and appropriate surgical therapy again becomes necessary, but with a very high risk.

The following case report illustrates the result of accurate diagnosis and immediate definitive therapy:

CASE REPORT

Mrs. M. C., a 71-year-old white widow, was awakened from sleep about 11:00 p.m. on the night of July 28, 1953, by the sudden onset of abdominal repair of an esophageal hiatus hernia sharp, excruciating, constant, substernal pain. This was followed within a few minutes by dyspnea, prostration, and a rapidly-appearing swelling in her anterior neck. Past history at another hospital in September, 1952; (2) she revealed the facts that (1) she had had a transhad lost considerable weight, perhaps from 180 down to 130 pounds, in the preceding year or so; and (3) she had been having mild, vague convulsive seizures, accompanied by brief periods of unconsciousness (known to the patient's friends, but not recognized by the patient herself) for an undetermined length of time.

The patient was brought by ambulance to Denver General Hospital and admitted to the emergency room at 1:10 a.m., July 29, 1953. She appeared critically ill, very weak, dyspneic and had rapid, gasping, labored respirations (40/min.) Her pulse was 120, the temperature was normal, and the blood pressure was 200/100. She displayed moderate cyanosis of the lips, face, and fingers. There was considerable subcutaneous emphysema of the lower face, anterior neck, supraclavicular fossae, and anterior chest. The lungs were clear; the heart sounds were distant; the abdomen was not remarkable.

A diagnosis of rupture of the esophagus was tentatively made at once, and confirmed within an hour by x-ray studies which showed mediastinal and cervical emphysema (Fig. 1) and extravasation of swallowed lipiodol into the posterior mediastinum (Fig. 2). At 4:25 a.m., four and one-half hours after onset of symptoms and three and one-half hours after hospitalization, the patient was given an endotracheal cyclopropane-ether anesthesia and a left thoracotomy was performed through the bed of the resected seventh rib. The pleural cavity contained about 200 c.c. of muddy, red-brown fluid; the mediastinal pleura over the lower esophagus was markedly edematous and emphysematous. By opening this area, a posterior mediastinal space was entered which contained approximately 100 to 200 c.c. of dark brown fluid and many small particles of undigested food. This space was evacuated and the esophagus was exposed. There was found to be a vertical rent, 5 to 6 cm. long, through the entire thickness of the left anterolateral wall of the lower thoracic esophagus, extending up almost to the arch of the aorta. The adjacent esophageal mucosa, visible through this opening, seemed rather friable, but otherwise normal. A Levine tube was introduced through the nose, and directed into the distal portion of the esophagus under direct vision. The esophageal defect was closed in a vertical linear fashion with an inner layer of continuous, inverting, Connell sutures of No. 0000 chromic catgut on an atraumatic needle, and an outer layer of interrupted Halstead sutures of No. 0000 black silk. An aqueous solution of 500,000 units of penicillin and 0.5 gms. of streptomycin and 0.5 gms. of oxytetracycline was then put into the mediastinum; anterior and posterior chest drainage tubes were inserted and the lung was re-expanded. The chest was closed in layers with interrupted sutures of No. 000 black silk. The patient tolerated the procedure surprisingly well and left the operating room in a condition essentially no worse than that in which she had entered it. During the operation she received 1,500 c.c. of whole blood.

The patient's postoperative course was complicated by a localized left empyema and a small

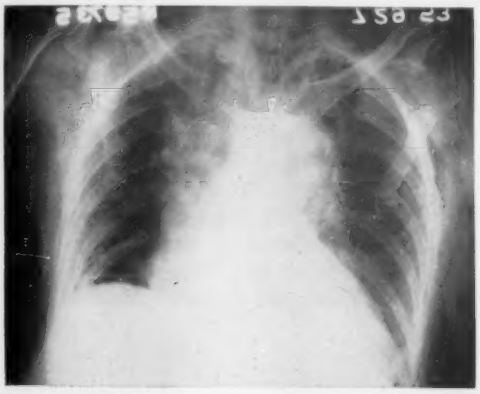

Fig. 1. Initial P-A roentgenogram of the chest showing the marked mediastinal, cervical and subcutaneous emphysema. This finding, together with dyspnea and the typical history leading to upper abdominal and lower chest pain, is diagnostic of rupture of the esophagus.

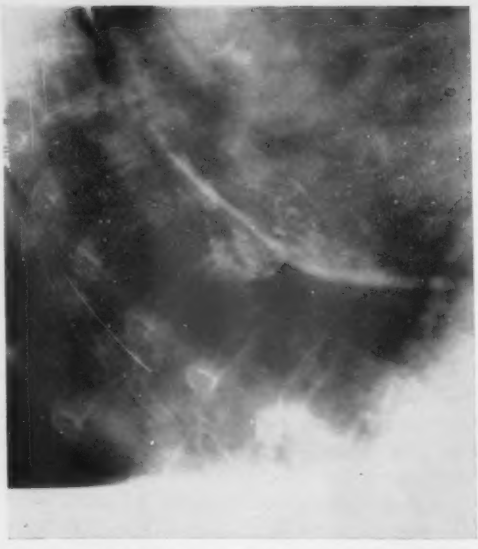

Fig. 2. X-ray confirmation of spontaneous rupture of the esophagus as obtained by demonstration of the extravasation of swallowed lipiodal into the mediastinal tissues.

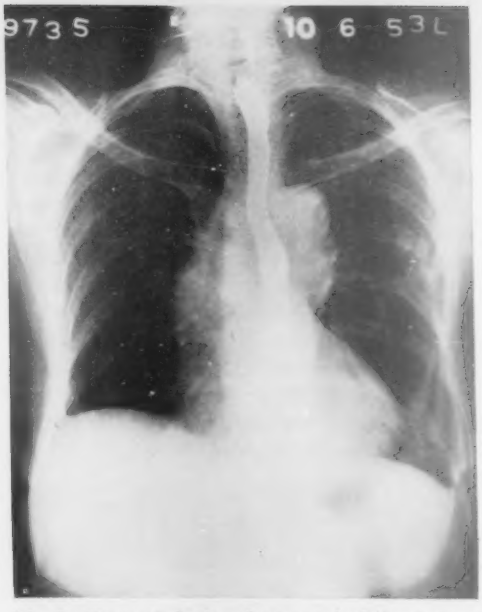

Fig. 3. X-ray study (esophagogram) of the case reported, taken six weeks postoperatively, shows the free passage of barium with only slight narrowing at the site of repair.

associated esophagopleural fistula, which developed on about the fourteenth postoperative day, and which were treated by tube thoracotomy with underwater drainage. She then went on to complete recovery, and was discharged home, in good health, on the thirty-fourth postoperative day. X-rays taken six weeks postoperatively (Fig. 3) showed almost complete clearing of the previously present pleural effusion; barium swallow disclosed a moderate narrowing of the esophagus at the point of rupture, but the barium passed with only slight delay.

When last seen, six months postoperatively, the patient was in continued good health, completely free of any dysphagia.

Discussion

The term "spontaneous rupture" as it applies to the esophagus, can be clarified by emphasizing the differentiation from true perforation. The latter situation will be found to be associated with such factors as direct trauma, erosion by either carcinoma, adjacent tuberculous nodes, esophagitis, aneurysm, caustic chemicals, or from impaction of a foreign body. Regardless of the exact causative factor, the true perforation may be found anywhere along the esophagus and is usually a punctate type of opening. Rupture of the esophagus, on the other hand, produces an acute longitudinal, linear tear, unassociated with any previous inflammatory process, and occurring almost exclusively in the lower one-half of the esophagus, usually beginning about one-half to one and one-half inches above the esophago-gastric junction.

Attempts to explain the findings associated with a spontaneous rupture of the esophagus were made by Mackenzie in 1880[11]. Recently Mackler has repeated and confirmed these experimental studies[6], and has shown that this lesion results from a bursting of the esophagus due to increased intraluminal pressure. Moreover, the site of predilection to this type of injury seems to be in the left lateral wall. Mackler accounted for the weakness in this area by three factors: (1) the quality of the musculature in the esophagus differs, the upper one-third contains exclusively cross-striated fibers like those of the pharynx, the middle one-third contains both striated and smooth muscles, and the lower one-third contains entirely smooth muscle fibers; (2) the upper one-half of the esophagus is reinforced anteriorly by the trachea; and (3) the muscle fibers in the lower one-third begin to splay out as they approach the stomach.

Essentially all cases of spontaneous rupture of the esophagus have been associated with vomiting, or with forces which acted upon the stomach in a similar fashion, such as childbirth, a convulsive seizure, blunt trauma to the abdomen, etc. This implies that there must be a full stomach, associated with a forceful contraction of the diaphragm and abdominal muscles. The result will be an explosive ejection of the gastric contents into the lower portion of the esophagus (Fig. 4). The question of whether some obstructive process, either organic or functional, is necessary to produce rupture is conjectural. In most instances a functional element, due to incoordination of the vomiting reflexes, can be postulated.

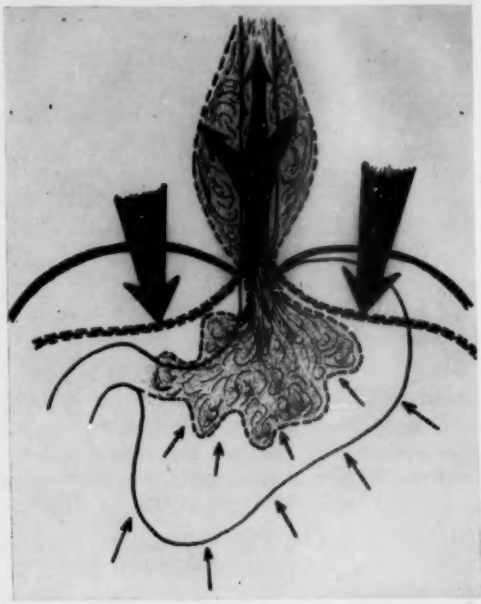

Fig. 4. Diagrammatic representation of the mechanism by which spontaneous rupture of the esophagus occurs. (Modified from Mackler.) See text.

The exact mechanism of the rupture in the case reported here is not clear. Ostensibly the rupture occurred during normal sleep. This is almost a unique event, only one similar case having been previously reported. It is altogether possible, however, that the patient may have had an unrecognized convulsive episode, possibly accompanied by vomiting.

This case is noteworthy also because of the very early development of subcutaneous emphysema. Oridinarily this appears only after two and one-half to twenty-four hours, and follows the digestion of the mediastinal tissues by the extruded gastric juice. Later it may result in the development of a pneumothorax or hydropneumothorax. Fortunately in this case, too, the superficial emphysema was an important sign leading to early diagnosis. Without some such clue as this one must rely upon the detection of mediastinal emphysema by either physical examination or x-ray.

It is very often essential that one have a high degree of suspicion, based upon the history and the location of the pain, or else the diagnosis may well be missed. Absence of the combination of such classic signs as a rigid upper abdomen, dyspnea, and subcutaneous emphysema means a differential diagnosis must be made. The intra-abdominal conditions with which this pathologic situation is most often confused are perforated peptic ulcer, acute pancreatitis, acute cholecystitis, renal colic and a dissecting aneurysm of the aorta. Within the chest, coronary thrombosis, pulmonary embolism, spontaneous pneumothorax, rupture of the diaphragm and an incarcerated diaphramatic hernia must be considered. However, the invariable association of thoracic and abdominal pain are symptoms which should immediately suggest a spontaneous rupture of the esophagus. Alt[8] has emphasized that when the clinical evidence creates an indecision as to whether the process is in the thorax or abdomen, one should consider the possibility of rupture of the esophagus.

It seems most appropriate to quote the prophetic words of Barrett, written *before* he encountered his first successfully treated case: "Several things are essential to success (in the management of this condition): first, a knowledge that the accident can and does occur; second, a knowledge of the symptomatology; and third, an early diagnosis. Given these, I am convinced that surgeons will be able to save some of these patients by combining the principles, already well established in the cases of abdominal perforations, with those relevant to thoracotomy[10]."

Conclusions

We have presented the case history of a patient with spontaneous rupture of the esophagus on whom the correct diagnosis and prompt, successful, surgical therapy resulted in a clinical cure. We have reviewed the etiology, symptoms, and physical findings associated with this acute emergency. It is emphasized that the history of combined upper abdominal and lower chest pain, appearing after vomiting and associated with dyspnea and subcutaneous emphysema of the mediastinum, neck or chest wall, is pathognomonic of spontaneous rupture of the esophagus. It is urged that this condition be considered in the differential diagnosis of acute emergencies of the upper abdomen and thorax.

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*Where Do You Fit In?**

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DURING the past several years I have spent so many hours talking to so many unhappy people, that I have found their unhappiness follows a definite pattern. As he goes along, the reader can decide for himself where he fits into this particular pattern. It has been said that no matter how rich, successful, or famous you are, without a happy marriage and a happy home, you have nothing. Recently, a prominent, successful man who possesses untold worldly goods, gave several million dollars to his wife to obtain his freedom. How unhappy he must have been to consent to pay that price to be free of her!

The basic unit of our society is the family. It starts with the union of a man and a woman in marriage. Almost immediately the first and most fundamental problem to confront them is sex. To a man, sex is the strongest single factor in married life. Indeed, wives often complain it is their husband's sole desire and interest.

Actually, sex is equally as important to a woman. She marries a man, not some strapping young woman with a good job to support her for the rest of her life. She never tires of a man saying, "I love you," particularly when he gives every indication that he means it. Naturally, it is preferable if that man is her husband. Obviously, however, there are differences in the sex outlook of a man and that of a woman. Those differences are obstacles which cause many marriages to fail, and make all marital adjustments difficult. Most men have a sex drive geared for a harem. Actually, in the vast majority of instances, one woman is easily sufficient to contain this sex drive if she learns to use her physical assets and emotions to their fullest extent.

A woman also has a strong sex drive, but from the time she is old enough to comprehend, the mores and taboos surrounding the feminine sex in our society are drilled into her. She can do this and she should not do that. Thus, even if a woman has one or several "affairs" before being married, she knows she is doing wrong. Therefore, when a woman is married, she carries with

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her a mass of inhibitions with regard to sex. Her training and inhibitions are both proper and necessary. When she is married, however, so far as this one man who is her husband is concerned, all of this training is expected to be dropped like a cloak and his passions and desires satisfied to the utmost.

Through novels and stories women are led to believe marriage is the answer to all their problems. The majority of fiction brings a beautiful heroine and a handsome hero together with the implication that they lived happily ever after. Anyone who has been married knows this is far from true. Marriage, instead, is a union of two people who are seeking the same goal. With and through each other, they endeavor to obtain that elusive, indefinite emotion which is happiness. Furthermore stories, which describe love-making, compound the emotional upheaval which occurs when two people are married. The heroine is usually depicted as drifting off into a semi-dream world of ecstasy and wakes up some time later happy and contented. Actually, when she makes love, a woman knows exactly what is going on at every moment. All too frequently, the experience is painful, distasteful and disappointing, both physically and emotionally. Even when she thoroughly enjoys the experience, she cannot help but feel that she has missed something because it was so far from any ecstatic dream-land which her reading had led her an anticipate.

The man also has his difficulties. Frequently, being timid, or restrained somewhat by his own training, it may be some time before all of a husband's desires are brought to the surface. Regardless of what they are, or how long it takes for them to appear, he is disappointed and often resentful if his wife does not respond to them passionately and without restraint. He, too, has read love stories. In them, the paramour is the pulsating epitome of passion. However, when he goes to bed that night, his wife says, "I'm too tired, and besides, it's all in your mind." He then, is disappointed, hurt and resentful. With these obstacles in the path of marital adjustment, and without even considering other differences in the personalities and training of the two individuals, it is easily understandable that happiness is not a foregone conclusion following marriage.

After a man and a woman are married they naturally make love. In the majority of instances, the woman either submits or consents to making love, or she rejects it. The reasons why a wife says, "No," to her husband are many and varied. Some of them make refusal entirely justified. However, no matter what the reason, when she says, "No," she is doing it to please *herself*. Thus she places her own desires first and she rejects her husband.

A woman who submits to her husband's love-making is, without realizing it, rejecting him almost as much as a flat refusal. A glaring example of this was related by a young woman to a circle of friends several weeks ago. She thought it very amusing when the previous night, as her husband had been making love to her, he suddenly began to jump up and down in the middle of the room, shouting with anger. The reason for his outburst was that while he was making love to her, she was reading a magazine and eating chocolates! Here was a woman who could very self-righteously say, "Sex cannot be the cause of trouble in our family, I *never* turn my husband down." Actually, her submission was as violent and emphatic a rejection as if she had told him to jump in a lake. Physically, essentially the same things happened to that woman and her husband as if she had been the most passionate wife in the world, but emotionally there would have been a tremendous difference. As it happened, he was furious, while if she had been passionate they would both have been pleased beyond words.

The rejected husband is unhappy and hurt. Whether this feeling is conscious or unconscious, being human, he responds by getting even and takes the first opportunity to say, "No," to his wife. Thus, he derives personal satisfaction in making her unhappy. The result is two people taking every opportunity to get revenge and, thereby, being selfish and perpetuating their unhappiness. They then gradually drift further and further apart in their trust and esteem for each other.

The result of this unhappy couple, drifting slowly apart, manifests itself in the wife by a variety of symptoms. Some of them are "nerves," crankiness, insomnia, "tired all the time," headaches, neuroses, "female" troubles, operations, loss of sexual satisfaction (which aggravates all other symptoms), excessive clubs (anything to get out of the house), personality problems, men and drink.

The unhappy man is more prone to turn to other women and drink. In addition, he likes to go fishing and attend various meetings or indulge in other activities which give him a so-called "legitimate" excuse to get out of the house and away from his wife and children. Just as with a woman's clubs, these activities are frequently justified but not when they are actually a manifestation of rejection. Other male symptoms are plain crabbiness, ulcers, insomnia, headaches, tiredness, personality problems and impotence.

The truly tragic result of the discord between these husbands and wives is the effect their unhappiness has on the people about them and most particularly on their children. The emotional conflicts of parents are reflected in their children. Like their parents, they exhibit numerous symptoms some of which are thumb sucking, bed wetting, nightmares, fingernail chewing, nose picking, delinquency, personality problems and a condition which may be referred to as "schoolitis." To me, "schoolitis" refers to the headaches, upset stomachs, nightmares, etc., which little Johnny or Mary has had "ever since school started." At times the symptoms are obviously due to the school environment and frequently one or another teacher is blamed for the child's difficulties. Sometimes a teacher or school official is grossly at fault, but in most instances the school situation is merely aggravating a child's emotional instability, the true origin of which lies with his parents.

President Eisenhower has very aptly stated that we should not talk about "delinquent children," but "parental failures." The children's problems are the result of the parents' maladjustments. Since becoming aware of this pattern of events, I have been more and more impressed by its reliability in discovering family problems. For example, after seeing a child who exhibits any of the above listed symptoms, one can predict with amazing certainty that his father and mother suffer from one or more of the disabilities which have been enumerated. The same can be said if a father or mother with any of these complaints is the first one to be seen. In such cases, one can expect to find the children and the patient's husband or wife to be afflicted with one or more of these ailments.

Many excuses are given by one parent or the other as the cause of his, or her, or their, "nervousness" and unhappiness. Money and business worries, relatives, and fear of pregnancy are high on the list. These are often aggravating influences, but are not the basic cause of emotional disturbances. A few months ago a woman called for an appointment for her husband. They lived in a small town a few miles away. He had been under treatment for heart trouble for over a year by a doctor in a nearby city, but they were much closer to our community so asked me to treat him. For several days he had been having severe pains around his heart. On inquiry, this wife stated that her husband was thirty years old. I observed that he was rather young for that type of heart trouble, but if he would come in, I would try to help him. After the husband arrived at the office, it developed that he also had gas and indigestion. However, his real trouble was that he had recently caught his wife stepping out on him.

True to the above pattern, about two months later his wife came in with a severe pain in the right lower quadrant of her abdomen. She had had a "chronic appendix" off and on for several years, but this attack was extremely severe. She was then rushed to the hospital—and a normal appendix removed. As she was recovering from her surgery, I was struck by the unhappy countenance of this young woman. In an attempt to help, I asked why she was so unhappy and why she and her husband did not get along better, so she unfolded her story. She, her husband and children

had lived in and owned a nice modern duplex in the city before moving to the small town. It was not only a good home, but modern in all respects, and also provided a source of income from the other apartment. The present family home not only had an outside toilet, but did not have running water. In fact, it did not even have a well, but a cistern which was filled from an irrigation ditch. So, how could I expect her to be happy? The thought of this attractive young woman having to use an outdoor toilet was enough to tear your heart out! However, after a moment's thought I asked, "Didn't you first start to step out on your husband when you lived in the city?"

"Yes," was the reply. "And to get even, didn't he leave you for a while and shack up with another woman for about a month?" "Yes," she again responded. "Actually, the toilet fixtures had nothing to do with those activities, did they?" I persisted. "No," was the final reply. The primitive conditions of their present home is an aggravating influence in the lives of this young couple, but obviously, it is not the cause of their unhappiness.

To complete the pattern it must be noted that almost every time I now see this woman, she wants a "book or something" to read because one behavior problem or another is being exhibited by one of her children. Actually, in this family, both the husband and wife thoroughly enjoy their love making. However, each is so intent on satisfying his own wants, desires and passions that there is almost constant strife between them and the whole household is unhappy.

Another excuse for marital unhappiness is frequently expressed in the statement, "He (or she) was no good when I married him (or her)." I can agree with that assertion wholeheartedly. Each and every one of us has a personality molded by the events and environment of our childhood and early life. Therefore, we primarily reflect the virtues, and are burdened by the faults of our parents or those who reared us. Since each of us is stuck with that personality, we should be tolerant rather than condemn the other. You were not allowed to choose your parents and neither was your wife. This raises the question, "Has marriage with you aggravated or improved your spouse's personality?" An amazing and pleasant surprise to me is that, in spite of all the people I have talked to, face or figure of husband and wife have never once been blamed as the cause of marital discord.

The remedy for unhappiness is easy for me to state, but extremely difficult to carry out. First, I ask that the husband and wife sit down and discuss their emotional problems and unhappiness. That is usually more easily said than done, as frequently one or the other "won't talk" or "always starts a fight." In order for it to be a discussion and not a family free-for-all, the husband and wife must be convinced that one is not a little tin god and the other a rotten apple, but that *each* is a rotten apple! It is *never* that just the husband or wife is at fault. Both are rotten apples and both are at fault! When they are convinced about that fact, they must sit down and say, "What is the matter with us? What is the matter with me? What can I do? I will do this to change!"—and do it!

If they blame each other they accomplish nothing except more dissension. If each blames himself, they are slightly better off, but still get nowhere. Regardless of who is to blame for what, the past is past and cannot be changed. All any of us can do is change, or modify, the future. Only by each husband and wife being convinced that he or she is a rotten apple and that he or she needs to, and *will* change, can the vicious cycle of the above pattern be modified or broken.

Each individual who tries to improve his personality has a task which requires his full attention and unceasing effort twenty-four hours of the day. Only by taking full command of ourselves and making a constant effort can we improve little by little. How can we possibly tell someone else what to do and expect them to change according to our wishes? We have little or no direct control over their emotions and such attempts will only serve to aggavate them. We must make every effort to improve ourselves and then others will react favorably

in response to our more pleasing personalities. In the discussions, and in the changes proposed and carried out, it must be remembered that there are a husband, and child or children, and a wife and child or children, involved. Each must be given his equal share of consideration at all times! Those who are model parents and spouses 90 or even 95 per cent of the time should remember, it is the remaining 10 or 5 per cent of selfishness that causes the trouble. This means that a change is still needed, but it should be comparatively easy to become a 100 per cent model parent. This advice is easy to give, but extremely difficult to apply. It requires insight, time and effort. All of us can see the faults of others, but it takes tremendous insight to see our own shortcomings. If you cannot see your own faults, simply take my word for it; you are not a tin god. You are a rotten apple, regardless of whom you have for a husband or wife!

Older people whose children are married and gone, or have had none, are also involved in this pattern of unhappiness. In recent months several women in their seventies have been in my office and left instructions that they would pay for their calls and their husbands would have to pay for their own. Have any of you older men (and younger ones as well) ever said, "My wife wants the kitchen painted, but I told her she could do it herself or pay for it out of her own money." When I think of the years of selfishness and rejection behind such statements, I have pity and sympathy for those people. How many years of unhappiness and existing, not living, are betrayed by such remarks?

All of us, and men in particular, should remember that not only the big things in life are important. Very small activities are frequently of tremendous significance. One day a young woman whom I had been treating because of insomnia came in for her weekly visit. I observed how happy she seemed to be. "I feel just fine," she exclaimed. "My husband stayed home all week-end. He didn't do anything big to upset me and I feel just fine!" I could not help but ask, "What is something big that he could have done to upset you?" After a moment's thought she responded, "He didn't leave his socks in the living room." If this husband visited you or me he would not leave his socks in the living room. He did not do it when he visited his mother or even his mother-in-law. However, who was his wife? What did she amount to, her subconscious mind apparently reasoned, when he dropped his socks wherever he happened to remove them? Materially this event was insignificant, but emotionally it was terrific!

A few weeks later this same woman was thrilled because her husband bought her a Coca-Cola! Usually, he went to the corner drug store, bought himself a "Coke," and returned home one or two hours later. This time, in response to his wife's treatment of love, affection and no rejection, he could not help himself, he wanted to be nice to her in return. He did not buy just one Coke, but two of them, and brought them home so his wife could have one with him. Materially, all he did was spend a dime on her, but the emotional effect was immense. He thought enough of her that he tried to please her and she was thrilled and happy.

One of the most common complaints of wives is that their husbands do not talk to them. The cartoon about a husband and his newspaper at the table is not a joke, but an act of rejection and an annoying habit in the eyes of his wife. If this man dined with you he would never do such a thing. The husband who does not talk, even without the intervention of a newspaper, is also being rude. The usual male response, when his attention is called to his failure to talk to his wife, is that he has nothing to say. Even salesmen will make such statements, though, should a visitor arrive, they can talk for hours. Here is a minor activity that does not cost so much as a wooden nickel, yet men tend to be so wrapped up in their own selfish thoughts and activities, that they fail to be decently civil to their wives and children when it comes to an ordinary conversation.

It is encouraging to note that men who do begin conversing with their wives find that these women are human beings after all. Also, once they get into the habit, it comes easily and is more enjoyable. One

woman whose husband started to converse with her remarked how she not only enjoyed it, but was immensely relieved. She had begun to feel that he considered her so far beneath him that she was too inferior to be able to hold a conversation with him.

Husbands and wives satisfy by never rejecting each other. Even if it happens very infrequently, when a marital partner says, "No," he is putting himself first and the other is being rejected. Anyone who is rejected is not satisfied, but unhappy. In seeking to please anyone, you must never ask, "What do you want?" Each must voluntarily, spontaneously, and joyously make every effort to please his mate both in and out of bed.

I feel that I can help any marriage by working with either the husband or the wife. More rapid progress can be made by both coming in for consultation, but if only the wife comes in, progress can be almost as fast because the most important task is to break down her inhibitions with regard to sex where her husband is concerned. These inhibitions may be a stumbling block to a satisfying love life and, consequently, a happy marriage. It should be possible for the husband to overcome these simply by being completely unselfish and doing everything possible to please his wife. However, I think any man is a great success if he overcomes his wife's self-interest by pleasing her without the added load of also needing to overcome her sex inhibitions.

Sometimes a man complains that it looks like he will have to do all the changing in his family. Actually, either the husband or wife can carry the whole load. However, by changing her sex inhibitions the wife can bring about the greatest changes in the shortest length of time. By pleasing her husband she makes him please her. If a husband pleases his wife, she has to respond and please him. Sex is the key to a happy marriage because it is such a powerful drive in the lives of human beings. Those people who spontaneously or by concerted effort are unselfish enough to place the sex needs of their partners before their own, find that to be unselfish in all other phases of married life is easy. When the partners in any marriage are completely unselfish, they have found happiness and love. Sexually, I advise all wives to do everything possible to arouse and stimulate their husband's passions. I tell them to try and imagine how the most passionate of wenches would act in bed with a man—and then try to outdo her. Actually, this is not nearly as drastic as it sounds. No matter how passionate a wife may be, physically nothing new will happen to her. Nothing will happen that has not happened many times before, but *emotionally* there will be no comparison.

It is not at all unusual for husbands and wives to see each other unclothed at, say 10 o'clock at night. However, how many women are horrified if their husbands want to undress them at 10 o'clock in the morning? Why? Would he see anything more? Could he do anything different? Obviously not, and any objections (barring children, visitors, etc.), are purely emotional and based on inhibitions. Recently, a young woman told me how she had gone to bed without her nightgown for the first time in twelve years of marriage. Physically it did not mean a thing because she was going to lose it anyway, but she pleased and stimulated her husband. The difference was purely emotional.

Some women object to being passionate because "he's never satisfied." If wives are *always* passionate, the husbands will be satisfied. However, no husband is ever satisfied when part of the time his wife is passionate, but the rest of the time merely submits or says, "No."

In addition, a satisfied husband is happy and pleased. In such a case, his wife has him caught, hook, line and sinker and he is glad of it! Being human, when he is pleased and happy, he cannot help himself and does everything he can to please his wife both in and out of bed. Instead of this husband and wife drifting apart because of rejection, they are brought closer and closer together by pleasing one another. Such a husband will not go fishing to get out of the house, or go out with other women, or just simply *have* to go on a vacation. If he did, what would he be looking for?

Most people are constantly searching for

a nameless something over the hill. They go on vacations and come home more exhausted than they were when they started; they become famous, yet are alcoholics; they become rich but have "nervous breakdowns;" they have numerous paramours yet are never satisfied; they desperately seek for something the key to which is in bed with them all the time. They are looking for happiness and *think* they know where to find it but never can. However, all the time it is so close, yet they fail to find it because of their own selfishness. Many women do not want to stimulate their husbands because then he will reach a climax too soon and "that makes a nervous wreck out of *me*." They think of themselves and not of their husbands. My answer is that in such activities a man is just like a boy with an ice cream cone. If he gobbles up his ice cream cone he knows that it is gone, so what does he do? He makes it last just as long as possible so he can prolong the deliciousness of its flavor.

The same is true in love making. If a wife can stimulate her husband enough, he may reach a climax in a hurry several times. However, very shortly two things happen. First, he realizes that his ice cream cone is gone and the memory is nothing compared to its actual enjoyment, so he prolongs his love making. Secondly, his wife is pleasing him and by so doing has him trapped because, being just another human being, he cannot help himself, but responds and does everything he can to please and stimulate her.

In that manner, but the husband and wife are stimulated and both enjoy the experience. Each has tried to please the other. They are brought closer together instead of drifting apart as they do when each tries to please himself first and the other one second, or not at all. A wife can thus not only satisfy her husband, but at the same time will exhaust him. Women who complain of their husbands' wanting to make love too frequently can curb their demands by wearing them out. Also, being pleased and satisfied, as well as exhausted, a husband again cannot help himself, but will try to please his wife and voluntarily make his advances less frequently in accordance to her desires. Happily, also, a woman often surprises herself. She finds that love making is now mutually more pleasurable than in the days when she was trying to primarily please herself, and thereby she is not only less reluctant to make love, but her own desires are increased.

Unfortunately, women whose husbands are sexually impotent, or are on the borderline of impotency, have a much more difficult problem on their hands. In these cases, the wives must have unlimited patience and unselfishness. In spite of all of their efforts, progress toward improvement of family troubles will be slow and discouraging.

In order that there be no misunderstanding, let me emphasize, I have *not* said you merely need to have a lot of sex and love making to be happy. I have tried to point out that to be happy you must be unselfish and if you are unselfish in your love life, the rest will be relatively easy. I have further tried to point out that a wife's inhibitions, which are entirely emotional, are the chief obstacle in the way of satisfying her husband's sex drive. If she does not satisfy it, he will not fulfill her need for love and affection. Then they will be unhappy and gradually drift apart as each selfishly looks out for himself.

Often, misunderstandings result not so much from what has been said, but why, and the manner in which it was said. I know of a young couple who had a quarrel which lasted for four days because the wife asked, "Where are you going?" It was not what she said, but why she said it and the way she said it. There are times when a husband or wife must say no. When one does, he must think carefully and ask, "Why?" and, "Am I saying 'No' to please myself?"

A few months ago, a young woman told me of how she had been greatly upset and hurt by her husband. She had wanted to remodel their front room and install a picture window. Her husband used excellent psychology when he said, "No," because he carefully explained how their income was limited and that they had several debts which needed to be paid. However, he

agreed that as soon as they were better situated financially, she could have her picture window. This wife, thus, did not feel rejected, but was pleased and happy—until the following week when her husband brought home a new television set! They could not afford a new window because her *husband* did not want one. He wanted a TV set. Because of that and similar rejections, it took several weeks of treatment before she could look at him again without wanting to shoot him.

Frequently a wife complains that her husband is going out with other women, or is always away from home for one reason or another. Sometimes a husband will voice similar complaints. For both, I have the same answer: Make it so much fun to be with you that your husband (or wife) will not want to be anywhere else. Husbands and wives are human beings. They like to enjoy themselves. They like to be in places that please them. They like to be with people whose company gives them enjoyment. Whenever it is more pleasurable to be with you than anyone else, that is exactly where your husband or wife will be at every opportunity.

Rejection is tremendously important. Remember that any fight, argument, or misunderstanding that you have ever had with your spouse or anyone else, starts with rejection. It starts with one putting his own wants, needs, pleasure, or opinion ahead of the other's. In the same manner, it is perpetuated. However, if it ever ends, it does so by each being nice and trying to please the other! Therefore, if one had stopped to please the other in the first place, there would have been no rejection and no hurt feelings. The satisfaction of revenge and "telling each other off" would have been foregone, but all the unhappiness would have been prevented.

It might well be asked, "Does this advice always work?" Unhappily it does not. In some cases, one of the partners will deliberately and willfully do everything possible to prove it wrong. In such instances, even if the other is conscientious and becomes completely unselfish, progress and improvement are slow and tortuous. In other cases, the couple will both deny the existence of any emotional conflict even though both exhibit definite symptoms which indicate its presence. These unhappy people I try to refer to a competent psychiatrist. Unfortunately, they are most often very reluctant to do so and not infrequently flatly refuse. All too often men and women undergo operation after operation and thus spend hundreds of dollars on obviously neurotic complaints, yet decline to consult a psychiatrist. The usual excuse is that it is too expensive because a psychiatrist's fees for office visits are high! One operation will pay for a great number of office calls even at the rates charged by psychiatrists. Oddly enough most of these people in my experience are very nice. They are not usually belligerent. They tend to cooperate in everything advised or recommended, except where their emotional entanglement is concerned. Because of this characteristic, even when a psychiatrist is consulted, the results obtained are often most discouraging.

Children are bits of clay who are molded by their parents. Their successes are their parents' successes, their failures are the reflections of the emotional conflicts and entanglements of their parents. If your child wets the bed, has nightmares, or is a delinquent, you are the one who needs help. You must inspect yourself and find where you are failing. The basic ingredients for happy well adjusted children are the same as for a happy marriage: Love, affection, and no rejection. Children need loads and loads of love. They need to be wanted and to know they are wanted. They must be made to realize they are wanted every minuate of the day. It must be demonstrated to them, time after time, by every word and gesture of their parents. What is a child who threatens or tries to run away but a helpless mite trying to escape from an unhappy home or situation? He actually is only imitating his parents who fish, golf, play bridge, etc., "to get out of the house." Children should never to rejected. If parents make it enough fun to be with them, their offspring will not be out roaming the streets, or living in a dream world created by comics, movies, or television.

When a parent says "No" to a child he

must make sure it is not merely to please himself. By adequate explanation he must be certain that the child knows and understands that it is for his benefit. The next time you want your children to be quiet, let it not be because, "You're getting on *my* nerves." Do not make your children beg for favors or assistance. Do not ask, "What do you want?" Instead, try at all times to anticipate their needs and suggest and take part in all possible activities which will give them pleasure.

As husbands, wives, and parents we are hypercritical of others, but make light of our own shortcomings. Praise your children for their accomplishments and minimize their mistakes. Your children love and respond to you when it is a pleasure to try to please you, not when you see only their faults and failures. The problem of discipline is a touchy one. There are times when it is necessary and of the utmost importance. *When indicated* it should be administered promptly and firmly. If children are allowed to go unrestrained and undisciplined they not only run wild, but begin to believe their parents do not love them enough to care what they do. They feel not wanted and that is one of the worst things that can happen to a child—or adult.

However, discipline must never be administered because a parent is simply out of humor, upset or nervous. It must *always* be used for the child's benefit and not for the parent's. Unfortunately, the reverse is usually true and is one of the reasons why it is so important that parents be happy and well adjusted. Discipline is also harmful when hastily administered before adequate investigation. All too frequently punishment is meted out where it was not deserved. It is then damaging in itself and too many parents fail to admit they were wrong. Such discipline gravely undermines the trust and esteem of their children.

It probably has been noted by many of you, that all of my references have been to my own practice and experiences. Actually, I have said nothing new. I have simply stated it in a different way with great emphasis on the importance of sex. I also want to emphasize that I am talking about your husband or wife, your parents, your brother, you sister, your friends and neighbors, but most important of all, I am talking about *you* and your children.

What you have read is actually a sermon, because long ago it was written in the Bible, "Love thy neighbor (even if he is another doctor, lawyer, merchant or chief) as thyself." It also says, "Do unto others (even if she is your wife, or he is your husband), as you would have others do unto you."

And lastly, remember how you get over any argument or misunderstanding? "If someone smites you on one cheek, turn the other." If you ever make peace after any disagreement you do so by being nice and pleasing to each other. If you turn the other cheek in the first place, all the harm will be avoided.

Therefore, in conclusion, I like to define happiness and love as that emotional state in which an individual *gladly satisfies* the wants, needs and pleasures of another in preference to his own.

A.M.A. OFFERS STANDARD NOMENCLATURE INSTITUTE

A new short course offering expert instruction and helpful suggestions on the correct way of utilizing "Standard Nomenclature of Diseases and Operations" in the hospital, doctor's office or clinic will be offered February 7-8-9 at A.M.A. Headquarters, Chicago.

Sponsored for the first time by the American Medical Association, the three-day Standard Nomenclature Institute program will be divided in three parts: (1) lectures covering basic principles, construction, installation plus discussion on the tumor and operation sections and handling of specific problems; (2) anatomy as it pertains to the topographic section, and (3) practice in coding to be offered at two evening sessions.

Because of limited facilities, registration will be limited to 150 "students." Application blanks will be distributed after December 1.

Instructors will be Adaline C. Hayden, R.R.L., associate editor of Standard Nomenclature, A.M.A., and Edward T. Thompson, M.D., F.A.C.H.A., Chief of Programs Operation, Hospital Facilities, U.S.P.H.S., Washington, D. C.

Care of Tuberculosis by The State of Colorado*

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AT THE annual meeting of the State Society in 1948, I gave a paper which explained the medical care of tuberculosis by the State of Colorado and how free care or partially free care is given to those of its residents who are suffering from active tuberculosis in any form and who are unable to finance their own care.[1] This paper is a progress report covering the intervening years.

First, I will review our methods in meeting the tuberculosis problem in Colorado. Tuberculosis is not only a medical problem, but an economic and public health problem as well. Over 90 per cent of those afflicted with the disease are unable to pay all of their costs of hospitalization; thus it has been necessary to meet the problem for the great majority of those afflicted at public expense. Therefore, the Division of Tuberculosis Hospitalization was established in 1937 by law as a division of the Colorado State Department of Welfare, and funds appropriated for its administration.

The requirements for this care are: 1. That a form shall be filled out by a licensed physician indicating that in his opinion the person has tuberculosis in an *active* stage of the disease. 2. That the individual shall have lived for the last twelve months in Colorado, and 3. shall be unable to pay for his own care (all or in part). Application must be made to the county welfare department in the county of residence, and a check is made by this county department of the length of residence and financial status before the application and medical summary are forwarded to the division headquarters for final action.

The interval between the time the patient signs his application in the county welfare office and the time he is in bed in a tuberculosis hospital or sanatorium is now an average of eighteen days. This interval could be shortened if the requests on the medical blanks for the results of sputum examination or, in the case of children, the tuberculin test, together with a recent chest x-ray, were more carefully observed by physicians. Physicians in Colorado have improved very much in recent years in their cooperation in this regard. We are all anxious to hospitalize the active case just as rapidly as humanly possible.

Because of the public health as well as the economic problem involved, every effort in recent years has been made to induce local welfare departments to give as liberal interpretation to need as possible, and I can report excellent progress in this regard over the past eight years. As few obstacles as possible should be put in the path of hospitalization. Patients who are able are asked to pay part of the cost of their care which averages $225 a month. It has been observed that patients who do contribute something to their care, are, on the average, better patients and take their treatment more seriously. The cost of care is borne equally by the state and the county from which the patient originates, and last year totalled $610,367.81.

Colorado has never had a state sanatorium —indeed, several legislatures turned down decisively the free gift of Phipps Memorial Sanatorium in Denver apparently on the ground that, unlike most states, Colorado had a number of good private institutions* for the tuberculous and these should be used for state cases. The system can work well, and the results are good as shown in the tables and charts that follow. The results are especially favorable when it is remem-

*Presented at the annual meeting of the Colorado State Medical Society, Colorado Springs, September 22-24, 1954. The author is Director, Division of Tuberculosis Hospitalization, Colorado State Department of Public Welfare.

bered that approximately two-thirds of our cases have been in the far advanced stage of the disease at the time of entrance during the eight-year period covered by these tables.

The legislature appropriated funds to establish in 1948 Ward A at the Colorado General Hospital for chest surgery and for diagnostic problems too complicated to be handled in the other institutions. This facility has been a valuable addition. Patients are transferred there for chest surgery, and they have the benefit of group support which is valuable when it comes to such procedures.

Each patient during his hospitalization is the responsibility of a physician with many years of experience in the treatment of tuberculosis. The progress of each case is reviewed with him, at least once in two months, by a team composed of the Director of the Division of Tuberculosis Hospitalization, a chest surgeon, a medical social worker, and usually also the head nurse, occupational therapist, and frequently a rehabilitation worker. Thus the patient has the benefit of all those with knowledge of his condition who can help with his problem and speed his recovery. This case conference also serves to bring about a measure of continuity and uniformity in the program —a somewhat difficult thing to achieve where patients are placed in so many different institutions.

Each patient receives a combination of usually two of the three anti-tuberculosis drugs now in common use—streptomycin, isoniazid and PAS. Treatment is continued as a rule until the sputum is persistently negative and the x-rays have shown little, if any, change for a period of four to six months. Those with persistent cavity after six months to a year of drug therapy are referred to the Colorado General Hospital for surgical evaluation. If the pulmonary function is adequate, some form of resectional surgery is performed, with or without tailoring thoracoplasty. A few have pneumonectomies and a few still receive the old type of thoracoplasty with removal of transverse processes. This latter procedure is free from immediate complications as a rule, but is much more difficult to "sell" to the patient (especially women) than a lobectomy or resection. Plombage operations are rarely used on our program, and then only as a last resort. Foreign bodies are not well tolerated. They do not as a rule produce the relaxation that nature requires to heal tuberculosis. Thirty years of observation leads me to believe that very few cases are helped by plombage and that many are made worse. Our cases receiving surgery are kept at bed rest for about four months following operation, and then gradually ambulated and discharged in two to four months. Drug therapy is continued throughout their period of hospitalization.

Every patient before discharge has a plan worked out for his future. If his condition is such that he cannot safely resume his previous occupation, a plan for vocational rehabilitation is made with the help of the Division of Vocational Rehabilitation of the Colorado State Department of Education. We do not as a rule discharge patients until they can resume remunerative work or are physically able to undertake training. No patient with a positive sputum receives a medical discharge except with the consent of the health department. There are very few in this category.

The following tables indicate the progress that has been made over the past eight years for patients cared for under our Division.

Of the cases admitted in 1953, there were sixty-four who had previously been under care under our Division. Of these, thirty-three (or 52 per cent) had previously left against medical advice; sixteen (or 6.4 per cent) previously had been discharged as inactive or arrested cases at some time since 1944; 13 (or 5.3 per cent) of admissions in 1953 represented relapses in cases thus discharged in the last four years. This does not seem unduly high when one considers

*Institutions to which patients are now sent are the following: Colorado General Hospital, Denver; Craig Colony, Denver; Lutheran Sanatorium, Wheatridge; National Jewish Hospital (children only), Denver; Swedish National Sanatorium, Englewood; Craigmor Sanatorium, Colorado Springs; Glockner-Penrose Hospital, Colorado Springs; Sunnyrest Sanatorium (ambulant cases only), Colorado Springs; St. Mary's Hospital, Grand Junction; Mennonite Hospital, La Junta. Each institution has been licensed by the Colorado State Department of Public Health for the care of tuberculosis and has, in addition, been approved by the State Board of Public Welfare for the care of state patients.

TABLE 1
Total Number of Cases Given Care for Tuberculosis

1946	338
1947	343
1948	379
1949	413
1950	442
1951	479
1952	501
1953	541

that many of our patients have to return to conditions that are inadequate as regards housing and nutrition.

In this connection life insurance statistics now show[2] that if tuberculosis remains arrested for five years the expected mortality rate is no higher than for a normal individual of the same age. If ten years after arrest, the mortality rate becomes appreciably better than average. Apparently the discipline acquired in curing one's disease pays dividends to the tuberculous individual in training him to safeguard his health in the future.

TABLE 2
Percentage of Cases Terminated as Inactive or Arrested

1946	9.8%
1947	18.4%
1948	36.0%
1949	30.0%
1950	52.0%
1951	40.4%
1952	44.7%
1953	55.0%*

*Sixty-five per cent if cases discharged to out-patient included.

Chart A and Table 2 show the percentage of cases discharged with their tuberculosis inactive or arrested in each year since 1946. The criteria for classification was changed a few years ago by the National Tuberculosis Association, and these new criteria were used for the data since 1950. Prior years are therefore not strictly comparable since they show the figures for "arrested" and "apparently arrested." Under NTA

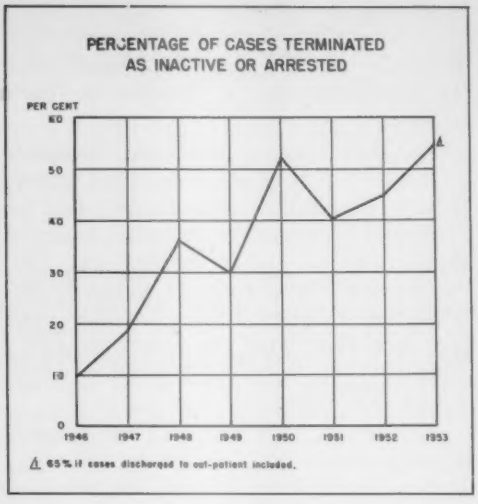


CHART A

regulations, it is now necessary to discharge any case showing x-ray evidence of cavity, even on planigrams, as "active," even though the individual may have been stable by x-ray for years and have a negative sputum. The remarkable improvement shown in the number of cases discharged as inactive or arrested in the past eight years is chiefly a reflection of the effect of drug therapy, though the chest surgeons also deserve much credit. Streptomycin was first used on our patients in 1947, PAS in 1949 and isoniazid in 1952.

TABLE 3
Deaths as a Percentage of Total Discharges

1946	28.0%
1947	26.0%
1948	23.0%
1949	22.0%
1950	14.5%
1951	17.4%
1952	15.2%*
1953	8.5%†

*This figure would be 11.7 per cent if non-tuberculosis deaths were excluded in 1952.
†This figure would be 6.3 per cent if non-tuberculosis deaths were excluded in 1953.

As one would expect, there has been a gratifying decline in deaths—almost a 75 per cent decline—as shown in Chart B and

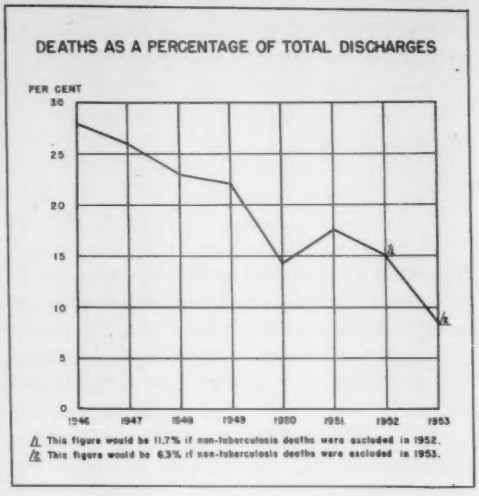


CHART B

Table 3. A patient can now be almost assured that his tuberculosis can be stopped and his life spared if he will cooperate in his treatment. The cases that still die or get worse are chiefly surgical casualties or those who are uncooperative.

We all hear a great deal these days about home care with the new drugs. Is it a wise procedure? A study was recently made by me of the results obtained under home care in some of the eastern states, and the answer to this question seems to be "No," except perhaps as a means of shortening a little the period of hospitalization. In Delaware and Chicago, home care has proved a dismal failure as a substitute for sanatorium or hospital care. It is found that treatment of tuberculosis has undergone such rapid changes in the past few years that many internists have not been able to keep up with these changes. Many of the patients treated at home have been unnecessarily made drug-resistant through ill advised use of one drug alone. Patients at home have not learned about their disease and how to protect others. They have been reluctant and often refuse to accept hospitalization if they become worse under home care. Many physicians do not understand the indications for chest surgery, and those who do, have found it almost impossible to persuade their patients to undergo surgery since these patients have not had a chance to observe the beneficial results as have those in institutions. Finally and perhaps most important of all, patients at home cannot be relied upon to faithfully take their medications over long periods of time, and this is all-important in preventing the development of drug resistance.

This past year we have undertaken in Denver a small pilot study of about fifteen selected cases on home care, in cooperation with Dr. Hilbert Mark and the Denver Tuberculosis Clinic. This study has had every advantage in that the patients have had skilled medical supervision combined with nursing supervision. Yet in this small group there have been cases that did not cooperate, and the patient that had the worst relapse while under home care refused hospitalization.

It does not therefore seem wise to undertake a program of home care in Colorado at this time. The older tried methods of institutional care still seem best for a disease as infectious as is tuberculosis. We are already beginning to receive a few patients that have been on prolonged home care therapy, and we find that they are very difficult cases to treat. It would therefore be unfortunate to run the risk of reversing the trend shown in the foregoing tables.

Just a final word dealing with the recent trend of tuberculosis in Colorado. In 1953 the reporting of new cases of active tuberculosis placed us in the most favorable third of states in this country with thirty-five new cases of active disease reported per 100,000 population against a national average of fifty. In 1945 there were twenty-six states with a lower death rate from this disease than in Colorado. In 1952 (latest figures available) there were only fifteen states with a lower death rate. Our death rate in 1953 was 10 per cent below the national average. The medical profession and all the agencies in this state working for the control of tuberculosis should take pride in this accomplishment.

REFERENCES

[1]Chapman, E. N.: "The Medical Care of Tuberculosis by the State of Colorado." Rocky Mountain Medical Journal, February, 1949.
[2]Ungerleider, H. E.: "The Internist and Life Insurance." Annals of Internal Medicine, July, 1954.

Five Hundred Cases of Erysipeloid*

ELI NELSON, M.D.
Denver

IN THIRTY years of general practice with special emphasis on industrial work, I have treated over 500 cases of erysipeloid. Two hundred and sixty occurred in packing house employees, 144 in rendering plants, 84 in hide establishments, and a few scattered about butcher shops, restaurants and fish stores. Nearly all occurred on the hand although one was seen on the neck of an employee caused by a hide thrown from a pile stirking him there, and another was on a foot, when a butcher killing sheep had his knife slip and cut through his shoe. Every physician in general practice and some of the internists will encounter these cases sooner or later in practice. The problem is to be aware of the condition and to recognize the entity. Too many physicians immediately think of a cellulitis and are too prone to incise the apparent infected wound, yet surgery is not necessary. Hence this paper—to make a plea for conservative non-surgical therapy in cases of erysipeloid.

Erysipeloid, or as often termed, erysipeloid of Rosenbach, is a relatively common cutaneous disease caused by infection, with a definite microorganism — erysipelothrix rhuseopathiae. Two confusing statements immediately should be settled by the above definition. First, erysipeloid should not be confused with human erysipelas of streptococcic origin. Second, and this is what has been the main stumbling block in the past, the erysipelothrix infection in swine has been referred to as "swine erysipelas" —not swine erysipeloid. The causative agent is a slender, small, straight or curved rod, a gram positive, non-motile, non-spore forming, micro-aerophilic bacillus. It may occur in a smooth or a rough phase and it may have a tendency to form branching filaments of variable lengths. Attempts to recover an organism from the lesion by usual methods of culturing small amounts of serum from wound or asperated material are unsuccessful. A culture of a small section of the skin usually shows the organism.

The organism first isolated by Pasteur in 1882 has a wide dissemination and infections have been reported in man, swine, sheep, mice, cattle, pigeons, horses, rabbits, fish and domestic fowl. It is capable of retaining its viability and virulence for months in putrid decomposing nitrogenous matter. It may exist as a saprophyte for months and then suddenly turn into a pathogenic parasite. Man is relatively immune, particularly when the organism enters through the gastrointestinal tract, but it has an affinity for skin tissue. Being quite resistant, it will resist drying for a month and will live in a refrigerator for a long time, but boiling is immediately destructive.

In swine it shows a predilection for the skin, joints and endocardium and three forms have been discussed; first, the mild or benign form, the so-called "diamond skin;" second, the chronic or arthritic form; and third, the septicemic or acute form. In the benign form, the skin of the animals shows a sharply circumscribed quadrangular bluish red lesion, while the arthritic form only involves certain joints. The acute manifestations are high fever, hemorrhagic nephritis, septicemic degeneration of the liver and heart with mortality in over 50 per cent in twenty-four to forty-eight hours.

Interest in erysipeloid in man dates from a report by Gilchrist in 1904, in which 329 cases were seen in Baltimore in persons handling crabs. Klauder, in Philadelphia, has written many articles on the subject

*Presented at the Colorado State Medical Eighty-Fourth Annual Session, Colorado Springs, Colorado, September 21-24, 1954.

since 1926 and in October, 1938, his address in San Francisco as chairman of the Section of Dermatology and Syphilology was titled "Erysipeloid as an Occupational Disease." He discussed the subject fully and gave credit to Fox in 1873 as first discovering the disease, although other authors gave credit to Baker in the same year. Rosenbach in 1884 gave it its name.

Later, there were reported a wide gamut of cases. Packing house employees, workers in rendering plants, handlers of fish, smoke dryers, meat inspectors, workers in button factories, fishermen, soap makers, bakers and housewives all have been infected. Bizarre cases also fill the literature —veterinary students dissecting calves, an attendant in a zoological garden handling a thawed fish, a person stung by a jelly fish, a hunter skinning a rabbit, a veterinarian doing an autopsy on a diseased animal, etc. Oddly, as to handlers of fish, erysipeloid rarely occurs on the Pacific coast but very frequently on the Atlantic coast. Contact with gurry or the remains of any fish undergoing putrefactive changes is a factor.

In the cases I have encountered, a complete history would have revealed a small cut which did not bleed or an abrasion to the hand of a worker slaughtering sheep, as if a burr of the sheep had entered the skin, or other direct contact with animal organic matter. An incubation period of two to seven days followed, then slight pain occurred around the site of inoculation. It seemed often that a little splinter or burr had entered the wound and many a butcher insisted that I should probe the wound for a burr. Itching, throbbing, burning and tingling ensued and then a stiffness around the adjacent joint, the finger becoming swollen as if some fluid had been injected intracutaneously, making the movements of the finger tender and difficult. Then the characteristic purplish rash slowly became evident—at first a small red spot on the finger, sharply defined and slightly elevated. The skin condition extended slowly peripherally by continuity as the central portion faded. It progressed to the back of the hand and often down the next finger, never above the wrist. The first area involved may have completely healed when a new area becomes purplish. It involuted without desquamation or suppuration, no fluctuation being present and no pitting on pressure.

Very few constitutional symptoms were evident. Low fever, up to 99.6 degrees F. in about 10 per cent of the cases, associated

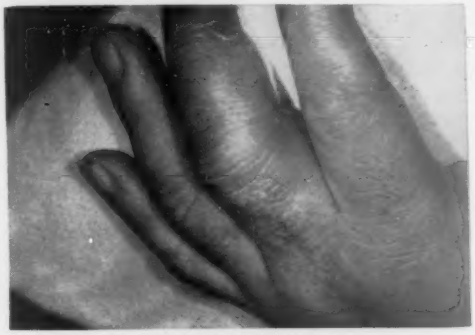


Fig 1. Finger swollen and stiff, as though injected with fluid.

Fig. 2. Characteristic well-defined, slightly elevated, purplish rash.

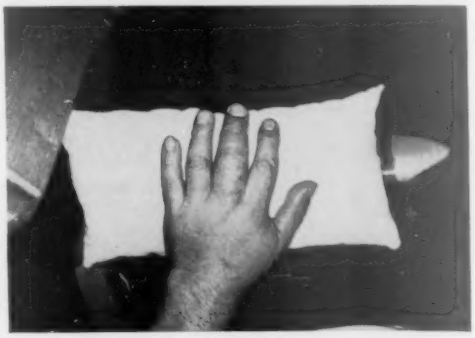


Fig. 3. Progression of pathologic condition to back of hand with adjacent finger—never above wrist.

with a mild headache and malaise occurred. Lymphangitis and adenitis were evident in 182 cases and arthritis in twenty-nine. The average duration before penicillin was discovered was seven days although one of mine lasted forty-five days. Most of the cases occurred in the summer months. Relapses were present in sixty-eight cases and one attack did not seem to give an immunity. Never have I seen a generalized cutaneous rash nor an acute septicemia. The disease is self-limited but penicillin lessened the duration of the entity. Only one case progressed to a necrosis of the bone, necessitating amputation of the finger.

Dr. Klauder reported a case of bacterial endocarditis where the generalized rash, purpuric and petechial in nature, simulated a meningococcus infection. A purplish-red hematoma-like swelling of the ears occurred associated with a generalized sepsis and a monocytosis, the erysipelothrix being found in blood culture. Death occurred in three weeks and the author concluded that erysipeloid septicemia should be considered when a clinical diagnosis of subacute bacterial endocarditis is ever made.

The diagnosis of erysipeloid should not be missed if the doctor is aware of the condition and considers the apparent injury, the sight of the inoculation, the slowly progressive lesion with its characteristic spread, and benign course. The absence of pus, the color, a normal leukoyte count, the location and slow progression will differentiate it from a true erysipelas, which is caused by a streptococcus, occurs on the face and scalp in 90 per cent of cases, and is more acute in its symtomotology. Of diagnostic import as to a pathogenic infection, the absence of suppuration, no pitting on pressure, no leucocytosis, rarity of regional lymphadenopathy and self-limitation of the disease should be deciding factors. Eczema can be distinguished by the presence of vesicles, activity of symptoms and marked itching. Erythemias are more chronic, occur on the trunk and do not have the characteristic violet color.

Regarding treatment, evaluation of specific chemotherapeutic agents is complicated by the fact that the disease is self-limited. Before penicillin was discovered a wide variety of locally applied drugs was used but these are not indicated at present. Splinting of the hand is still advisable and the use of wet dressings or 10 per cent ichthyol is beneficial. At the present time polymixin and neosporin are used locally. Parenteral administration of penicillin and especially bicillin are the antibiotics used now. Sulfonamides are of no value. In individuals allergic to penicillin some of the broad-spectrum antibiotics are good, especially achromycin and terramycin. Streptomycin is not beneficial. Immune serum which was formerly used and is still available from several of the pharmaceutical houses is being discarded as the incidents of serum sickness are high. Surgery is not necessary and should be avoided.

Conclusion

Among packing house and associated companies, I have seen over 500 cases of erysipeloid and treated them conservatively. Surgery was not necessary except in a few cases. The diagnosis was obvious, showing strict limitation of the process to one location, usually the hand, clinical appearance of the erythematous edematous lesion with tenderness of the parts, and the characteristic violaceous color with clearing in the center while slowly spreading peripherally. Penicillin was the treatment of choice.

CORRECTION

An error in Dr. Lloyd G. Lewis' article, "Cancer of the Genito-Urinary Tract," appeared in the September issue of this Journal on Page 797 and we are publishing a correction as follows:

"Conclusion

"2. That early operable carcinoma of the kidney pelvis, ureter or bladder could be detected by thorough urologic investigation of every patient with microscopic hematuria."

Treatment of Cervico-Facial Actinomycosis With Isoniazid*

L. W. Greene, M.D., and W. C. Black, M.D.
Denver

A REPORT of the treatment of three cases of actinomycosis with isoniazid has been made by McVay and Sprunt[1]. We wish to add another case in which beneficial results were obtained in actinomycosis by the use of isoniazid.† Comments on rapid identification of the Actinomyces by a histological method, and on testing its sensitivity to antibiotics are also included.

CASE REPORT

A white married woman, 34 years of age, presented herself for examination on September 18, 1953, with the following history:

On April 22, 1953, she consulted her dentist concerning a swelling of alveolar tissue of the lower jaw on the left, in the vicinity of the lateral incisor, where she had bruised her gums by picking her teeth with a broom straw a few weeks previously. Her dentist incised the swelling and a small amount of "creamy fluid" escaped. No bacteriologic examination of this material was made.

On May 7, 1953, she developed what her physician diagnosed as Ludwig's angina. There was board-like swelling of the neck and her tongue enlarged until it filled the oral cavity. There was accompanying fever, up to 104°, for ten days with loss of about fifteen pounds in weight. X-ray studies of the jaws showed no significant abnormalities. A swelling "about the size of an egg" persisted below the mandible, on the left. This lesion "pointed" through the skin. The resulting sinus was probed and curetted at intervals of three or four days for about two months. Bacteriologic cultures of whitish fluid thus obtained, yielded a growth of Staphylococcus albus and an hemophilus influenzae-like organism, which was found to be sensitive to streptomycin.

During this time she has been treated with antibiotics and sulpha compounds including all of the well-known antibiotics and their combinations with sulpha compounds.

On September 9, 1953, she felt as though she had an ulcerated tooth. Her tongue became greatly swollen. X-ray studies again failed to disclose significant changes. There was difficulty in swallowing and fever of 103°. On September 18, 1953, she was referred to one of us with the chief complaint of "abscessed jaw for five months." Examination revealed a swelling in the left sublingual region, with sinus formation and keloid change in the bordering skin (Fig. 1). Two small openings were present, separated by about 1.2 cms. The skin over the swelling was dusky bluish-gray and the underlying tissues felt very firm and coarsely nodular.

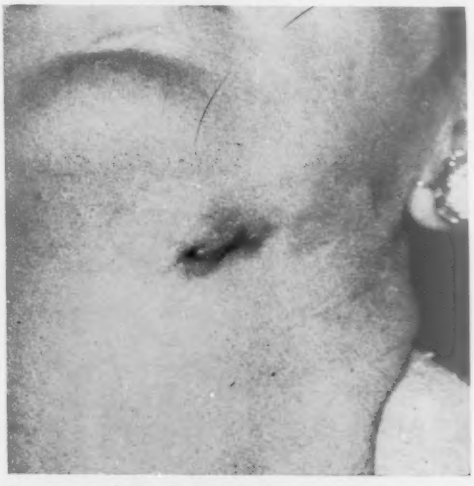
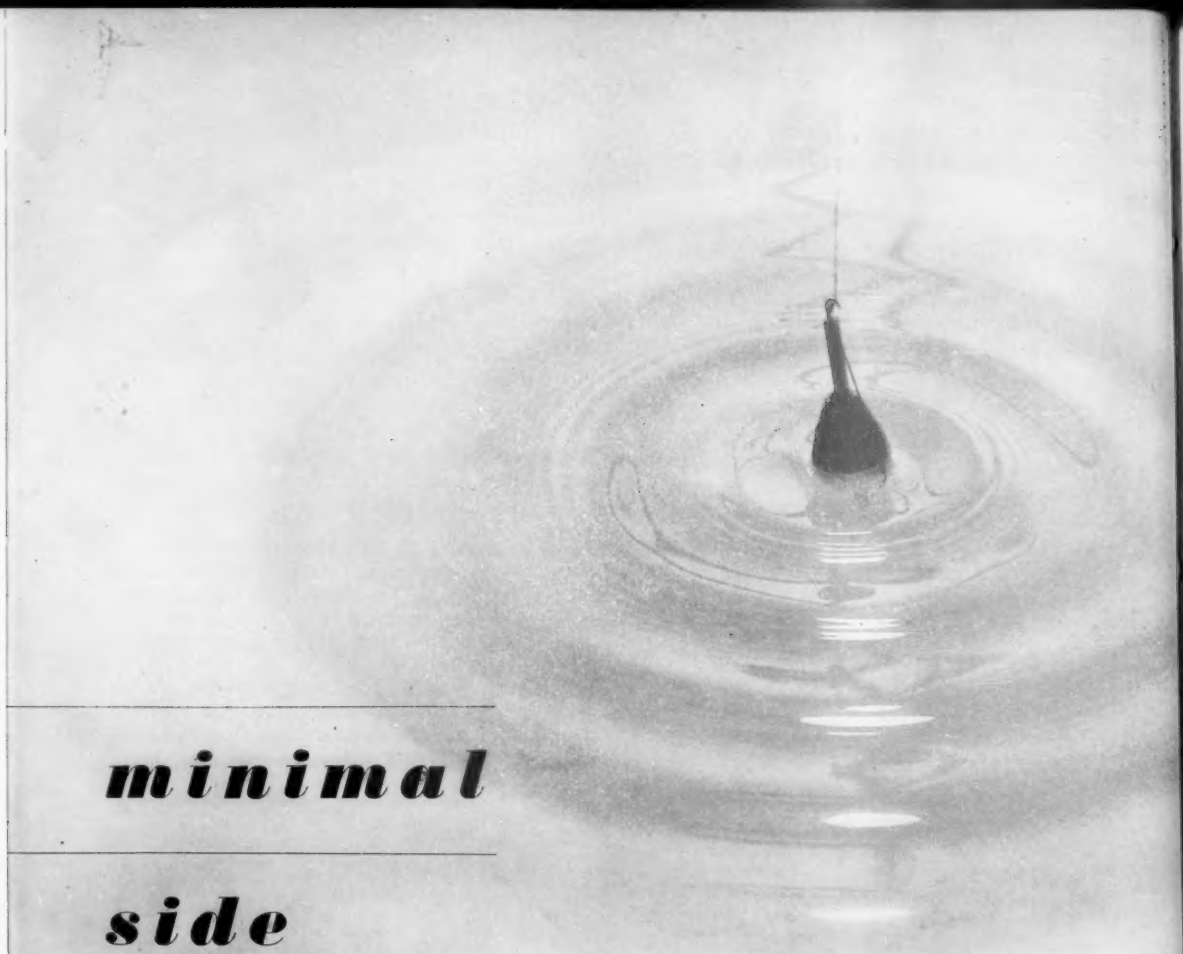


Fig. 1. Lesion below chin with one sinus opening visible.

Gentle pressure applied by the patient forced greenish-white turbid fluid out of both sinus openings. The fluid was not particularly viscous and was easily collected in sterile test tubes. About 0.5 ml. was obtained in each of two tubes. By tilting and rotating the tubes, small pale greenish masses, less than 0.1 cm. in diameter, were demonstrable. One test tube was kept sealed for cultures. Using a wire loop some of the greenish masses were lifted out on a slide

*From the Oto-Rhino-Laryngology and Pathology Divisions, Staff of St. Luke's Hospital.

†Donated for trial by E. R. Squibb Company.



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In each of its various dosage forms, ACHROMYCIN provides more rapid diffusion for prompt control of infection. In solution, it is more soluble and more stable than certain other antibiotics.

ACHROMYCIN has proved effective against a wide variety of infections caused by gram-positive and gram-negative bacteria, rickettsia, and certain virus-like and protozoan organisms.

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and crushed under a cover slip. Immediate microscopic study disclosed typical actinomyces granules but without well defined marginal clubs. Cultures were started and 10 per cent aqueous solution of formaldehyde U.S.P. was added to the residual fluid obtained from the sinuses. After twelve hours' time allowed for fixation, the fluid was centrifugalized and the sediment dehydrated and embedded in paraffin for sectioning, following the standard method used for tissues. Sections so obtained were stained with hematoxylin and eosin, carbol-fuchsin and by Gram's method. The sections contained readily identifiable Gram positive nonacid fast actinomyces bovis (Fig. 2).

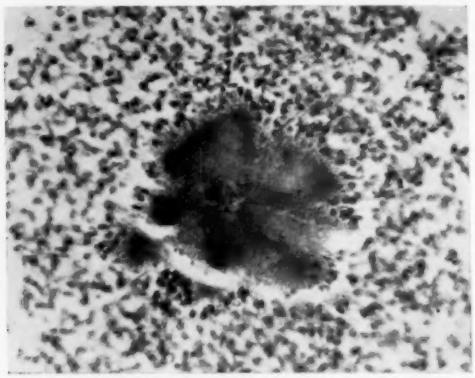


Fig. 2. Photomicrograph x 200 actinomyces bovis colony in purulent exudate.

Use of this method permitted identification of the organism within twenty-four hours. After obtaining the organism in culture, sensitivity tests were performed using the tube dilution method with the following result: Iso-nicotinic acid-hydrazid 16 micrograms per M.L., resistant; the same, 32, 65, 133, 266, and 455 micrograms per M.L., sensitive.

The patient was hospitalized on September 25, 1953, for treatment. Complete physical examination, chest radiographic studies, and laboratory procedures were carried out. Physical examination revealed no abnormality except the lesion as described. Her temperature remained normal throughout the hospital stay of seven days. Laboratory findings during hospitalization include sedimentation rate, Westtergren, 7 mm. in sixty minutes; urinalysis, normal. Blood count: R.B.C. 4,610,000, Hb. 91 per cent, 14 grams; W.B.C., 11,800. Differential count: Seg. 59, Lymp, 36, Mono 1, Juvenile 1, Eosin. 1. Brewer's thiolglycholate broth and deep agar shake tubes yielded a good growth of typical actinomyces bovis after five days' incubation. Second culture in the same media on October 18, after therapy, yielded scant growth in one tube only. A roentgenogram of the chest made on September 25, 1953, showed nothing abnormal.

Following the dosage of isoniazid suggested by McVay and Sprunt (ibid) using Nydrazid (Squibb), the patient was given 300 mg. of the drug orally per day beginning September 26, 1953, and the dose increased to 500 mg. on September 29, 1953, and then to 900 mg. per day on October 9, 1953. During this time gradual regression of the induration and reduction in the amount of exudate took place. The dosage was maintained at 900 mg. daily through December 20, 1953, then reduced to 300 mg. daily until January 20, 1954. With practically complete disappearance of induration and discharge, isoniazid was reduced to one 300 mg. dose every tenth day and discontinued entirely in March, 1954, when all induration had disappeared and the sinuses had apparently healed.

Discussion

McVay and Sprunt (ibid) believe that larger amounts of isoniazid are necessary in actinomycosis than in tuberculosis and recommend the use of 10 to 18 mi. per kilogram per day. Patients on dosage as large as this should be observed carefully for signs of toxicity. Neurologic disease, history of psychosis or evidence of serious renal or hepatic disease might contraindicate the use of isoniazid.

The patient has had two radiographic chest examinations, with no abnormalities noted, and two physical examinations. She was examined most recently on September 17, 1954. She has remained symptom free, has gained weight, and has only a slightly retracted scar at the site of the former lesion.

Summary

A case of cervicofacial actinomycosis, apparently successfully treated with isoniazid is reported. Because of the large dosage required careful observation for signs of toxicity is necessary and some contraindications to the use of the drug may exist. Rapid identification of the microorganism can be accomplished by formalin fixation of exudate followed by paraffin embedding and sectioning of the sediment, before growth in culture is obtained. Actinomyces bovis may be tested for antibiotic sensitivity by the use of serial dilutions of the drug in liquid culture media.

REFERENCE

[1]McVay, L. V., Jr., and Sprunt, D. H.: J.A.M.A., Vol. 153, No. 2, Pgs. 95-98, September, 1953.

Dramamine's® Effect in Vertigo

Dramamine has become accepted in the control of a variety of clinical conditions characterized by vertigo and is recognized as a standard for the management of motion sickness.

Vertigo, according to Swartout, is primarily due* to a disturbance of those organs of the body that are responsible for body balance. When the posture of the head is changed, the gelatinous substance in the semi-circular canals begins to flow. This flow initiates neural impulses which are transmitted to the vestibular nuclei. From this point impulses are sent to different parts of the body to cause the symptom complex of vertigo.

Some impulses reach the eye muscles and cause nystagmus; some reach the cerebellum and skeletal muscles and righting of the head results; others activate the emetic center to result in nausea, while still others reach the cerebrum making the person aware of his disturbed equilibrium. *Vertigo may be caused by a disease or abnormal stimuli of any of these tissues involved in the transmission of the vertigo impulse, including the cerebellum and the end organs.*

A possible explanation of Dramamine's action is that it depresses the overstimulated labyrinthine structure of the inner ear. Depression, therefore, takes place at the point at which these impulses, causing vertigo, nausea and similar disturbances, originate. Some investigators have suggested that Dramamine may have an additional sedative effect on the central nervous system.

Repeated clinical studies have established Dramamine as valuable in the control of the symptoms of Ménière's syndrome, the nausea and vomiting of pregnancy, radiation sickness, hypertension vertigo, the vertigo of fenestration procedures, labyrinthitis and vestibular dysfunction associated with antibiotic therapy, as well as in motion sickness.

Any of these conditions in which Dramamine is effective may be classed as "disease or abnormal stimuli"* of the tissues including the end organs (gastrointestinal tract, eyes) and their nerve pathways to the labyrinth.

Dramamine (brand of dimenhydrinate) is supplied in tablets of 50 mg. and liquid (12.5 mg. in each 4 cc.). It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

The site of Dramamine's action is probably in the labyrinthine structure.

*Swartout, R., III, and Gunther, K.: "Dizziness:" Vertigo and Syncope, GP *8*:35 (Nov.) 1953.

The Washington Scene

A monthly news summary from the nation's capital by the Washington Office of the A.M.A.

Because this is a new Congress and under new leadership, a number of new bills can be expected in the health field. But the Democrats also can be expected to devote a vast amount of time to health legislation that was previewed last session by the Republicans.

In fact, one of the more prominent bills on the list, that providing federal reinsurance of health insurance plans, was subjected to lengthy hearings before it finally met defeat in the House late in the last session. So thoroughly was it dissected then that it will be surprising if the friends of reinsurance can find anything else favorable to say about it, or its critics can find anything else wrong with it. How this Republican bill will fare in Democratic committees now is one big question.

There is always the possibility, of course, that some of the major bills to be presented again will be so amended that new decisions will be called for. For example, the administration's experts all fall have worked tirelessly to make the reinsurance bill more palatable.

Like the reinsurance bill, the proposal to revamp the procedure for distributing public health grants to states was well worked over last session. It passed the House, but the Senate committee was unable to untangle all the knots it discovered, so there was no final action. This, too, is up again this year, labeled as difficult and touchy but nonpartisan.

Another well-advertised bill coming up for action is that to set up a program of contributory health insurance for federal employees. Last session a Senate committee held a one-day hearing on this bill, admittedly merely to get the proposition "on the record" so it could be freely discussed between Congresses. A task force from the Civil Service Commission has been trying to hammer out a more workable version of the bill, and has found the task a formidable one. But despite the complications, Congress will be asked to enact some bill of this type.

Although the bill definitely is of Republican origin, there is no reason to expect that it will receive a hostile reception from the Democrats in either House. It is generally accepted as a too-long delayed attempt to bring the federal government into line with private industry.

The bill for expanding medical care for military dependents has about the same history. After months of planning and conferences, bills were introduced last year in House and Senate to get the idea out into the open for the benefit of Congress and the public. Because the plan is so highly controversial, however, no hearings were held last session. The same bill is going before Congress again.

Here the fundamental issue is whether military hospitals and uniformed physicians shall supply the preponderance of this service to dependents, or the dependents shall be treated largely by civilian physicians and in civilian hospitals.

Last session the Defense Department prepared the draft of a bill to set up a number of military medical scholarships. Because bills originating in one department that might affect another first must be submitted to the latter for comment, this bill was turned over to Mrs. Hobby's Department of Health, Education, and Welfare. There it rested until after Congress adjourned. The 84th Congress will be asked to enact the bill, possibly as an alternative to extending the Doctor Draft, which is scheduled to expire next July 1.

Efforts will be made, but not necessarily with the Eisenhower administration's help, to enact some sort of legislation for federal guarantee of hospital mortgage loans. This subject was gone into in great detail last session by Mr. Wolverton's House Interstate and Foreign Commerce Committee, but the committee finally turned down Mr. Wolverton and refused to report out the bill for action. It had widespread labor support last year, but was opposed by the A.M.A. as discriminatory, in that it would offer more assistance to closed-panel practice than to other forms of medical practice.

Indications are that Mrs. Hobby's department will sponsor legislation to aid medical schools, a subject that was not taken up in the last Congress but that attracted considerable attention in years past.

AMERICAN ACADEMY OF FORENSIC SCIENCES MEETING

The Seventh Annual Meeting of the American Academy of Forensic Sciences will be held in the Biltmore Hotel in Los Angeles on February 17, 18, 19, 1955. The President of the Academy this year is Dr. A. W. Freireich, Malverne, New York, and the Chairman of the Program Committee is Dr. Milton Helpern, Chief Medical Examiner of the City of New York. The Law Department of the American Medical Association has long urged that the profession take an increasing interest in medicolegal problems and the programs of the Academy meetings are a definite step in that direction. Further information may be obtained by writing Dr. W. J. R. Camp, University of Illinois College of Medicine, 1853 West Polk Street, Chicago, Illinois, Secretary, or Dr. Frederick D. Newbarr, 109 Hall of Justice, Los Angeles 12, California, Chairman of Local Committee on Arrangements.

PROGRAM*

Twentieth Annual Midwinter Postgraduate Clinics, February 15, 16, 17, 18, 1955, Denver, Colorado

Presented to the Rocky Mountain Region by the Colorado State Medical Society

Headquarters: Shirley-Savoy Hotel
Registration Fee: $5.00

TUESDAY, FEBRUARY 15

ALL DAY

Advance registration and installation of exhibits at Shirley-Savoy Hotel

AFTERNOON

4:00—Interim Session, House of Delegates; Colorado Room, Shirley-Savoy Hotel.

EVENING

6:30—Dinner, to be followed by Stag Smoker; Lincoln Room, Shirley-Savoy Hotel.

Dinner Speaker: Francis R. Manlove, M.D., Denver: "The Role of the Medical Center in the Community."

WEDNESDAY, FEBRUARY 16

MORNING

9:00—Registration opens at the hotel and at both hospitals. (Note: Clinics will be conducted at two hospitals simultaneously).

SECTION A—Clinic on Obsetrics and Gynecology, Colorado General Hospital, East Ninth Avenue at Ash Street. E. Stuart Taylor, M.D., Denver, presiding.

10:00-11:30—Cases presented by staff of Colorado General Hospital. Discussion by James F. Rinehart, M.D., San Francisco, and Bayard Carter, M.D., Durham.

SECTION B—Clinic on Cardiovascular Conditions, Children's Hospital,. East Nineteenth Avenue at Downing Street. John R. Connell, M.D., Denver, presiding.

10:00-11:30—Cases presented by staff of Children's Hospital. Discussion by Conrad Lam, M.D., Detroit, and Fred J. Hodges, M.D., Ann Arbor.

NOON

Shirley-Savoy Hotel

11:30—All Exhibits Open.

12:30—Luncheon and Round Table Discussion: Colorado and Centennial Rooms, Shirley-Savoy Hotel.

Kenneth D. A. Allen, M.D., Denver, Vice-President, Colorado State Medical Society, presiding.

Question and answer period conducted by James F. Rinehart, M.D., and Bayard Carter, M.D., relating to obstetrics and gynecology.

AFTERNOON

Lincoln Room, Shirley-Savoy Hotel

B. J. Sullivan, M.D., Laramie, President, Wyoming State Medical Society, presiding.

Symposium on Obstetrics

2:00—Introductory Remarks—Samuel P. Newman, M.D., Denver, President, Colorado State Medical Society.

2:05—"Gall Bladder Disease in Pregnancy"—Robert S. Sparkman, M.D., Dallas.

2:25—"The Pregnant Diabetic"—Richard W. Vilter, M.D., Cincinnati.

2:45—"Vaginal Bleeding in Late Pregnancy"—Bayard Carter, M.D., Durham.

3:05—Intermission to Study Exhibits.

3:35—"Radiological Problems in Obstetrics"—Fred J. Hodges, M.D., Ann Arbor.

Panel on Obstetrics—Moderator: Lyman W. Mason, M.D., Denver.

3:55—Robert S. Sparkman, M.D., Dallas; Richard W. Vilter, M.D., Cincinnati; Bayard Carter, M.D., Durham; Fred J. Hodges, M.D., Ann Arbor.

4:00—Adjourn.

4:00—House of Delegates. Second Meeting of Interim Session—Colorado Room.

4:30—Exhibits Close for the Day.

EVENING

Open Date.

THURSDAY, FEBRUARY 17

8:30—Registration opens at hotel and hospital.

MORNING

Denver General Hospital, West Sixth Avenue and Cherokee Street. N. Paul Isbell, M.D., President, Denver General Hospital Staff, presiding.

*A more detailed program, pocket-size, will be mailed about January 20 to all members of The Colorado State Medical Society and to any other physicians who request it.

9:30-11:30—Clinic on Trauma. Cases presented by staff of Denver General Hospital. Discussion by Robert S. Sparkman, M.D., Dallas, and Conrad Lam, M.D., Detroit.

NOON

Shirley-Savoy Hotel

11:30—All Exhibits Open.

12:30—Luncheon and Round Table Discussion. Colorado Room, Shirley-Savoy Hotel. Samuel P. Newman, M.D., Denver, President, Colorado State Medical Society, presiding.

Question and Answer period conducted by Conrad Lam, M.D., Detroit; Robert S. Sparkman, M.D., Dallas, and Fred J. Hodges, M.D., Ann Arbor; relating to cardiovascular and traumatic problems.

AFTERNOON

Lincoln Room of the Shirley-Savoy Hotel

Charles Ruggeri, M.D., Salt Lake City, President, Utah State Medical Association, presiding

Symposium on Pulmonary and Cardiac Conditions

2:00—"Preoperative Evaluation of the Patient"—Richard W. Vilter, M.D., Cincinnati.

2:20—"Pregnancy in the Cardiac Patient"—Bayard Carter, M.D., Durham.

2:40—"Differential Diagnosis of Upper-Gastro-intestinal and Cardiac Lesions"—Morris E. Dailey, M.D., San Francisco.

3:00—Intermission to study exhibits.

3:30—"Cardiac Resuscitation" — Conrad Lam, M.D., Detroit.

3:50—"Pathology of Postoperative Chest Lesions"—James F. Rinehart, M.D., San Francisco.

Panel on Pulmonary and Cardiac Conditions: Moderator: Robert S. Liggett, M.D., Denver.

4:10—Richard W. Vilter, M.D., Cincinnati; Bayard Carter, M.D., Durham; Morris E. Dailey, M.D., San Francisco; Conrad Lam, M.D., Detroit; James F. Rinehart, M.D., San Francisco.

5:00—Adjourn.

5:30—Exhibits Close for the Day.

EVENING

6:00—Social Hour, Colorado Room, Shirley-Savoy Hotel.

7:00—Dinner dance and entertainment; Silver Glade of the Cosmopolitan Hotel; sponsored by the Woman's Auxiliary to the Colorado State Medical Society.

8:30—"Candid Capers," Special Entertainment.

9:30—Dancing.

FRIDAY, FEBRUARY 18

MORNING

8:30—Registration opens at hotel and both hospitals. (Note: Clinics will be conducted at two hospitals simultaneously).

9:30-11:30—Two Simultaneous Clinics on Gastro-enterology.

SECTION A—St. Luke's Hospital, 1933 Pearl Street. William R. Lipscomb, M.D., Denver, presiding.

Cases presented by staff of St. Luke's Hospital. Discussion by Robert S. Sparkman, M.D., Dallas; Fred J. Hodges, M.D., Ann Arbor; Richard W. Vilter, M.D., Cincinnatti.

SECTION B—Presbyterian Hospital, East Nineteenth Avenue and Gilpin. Howard Bramley, M.D., Denver, presiding.

Cases presented by staff of Presbyterian Hospital. Discussion by Conrad Lam, M.D., Detroit; James F. Rinehart, M.D., San Francisco; Morris E. Dailey, M.D., San Francisco.

NOON

Shirley-Savoy Hotel

11:30—All Exhibits Open.

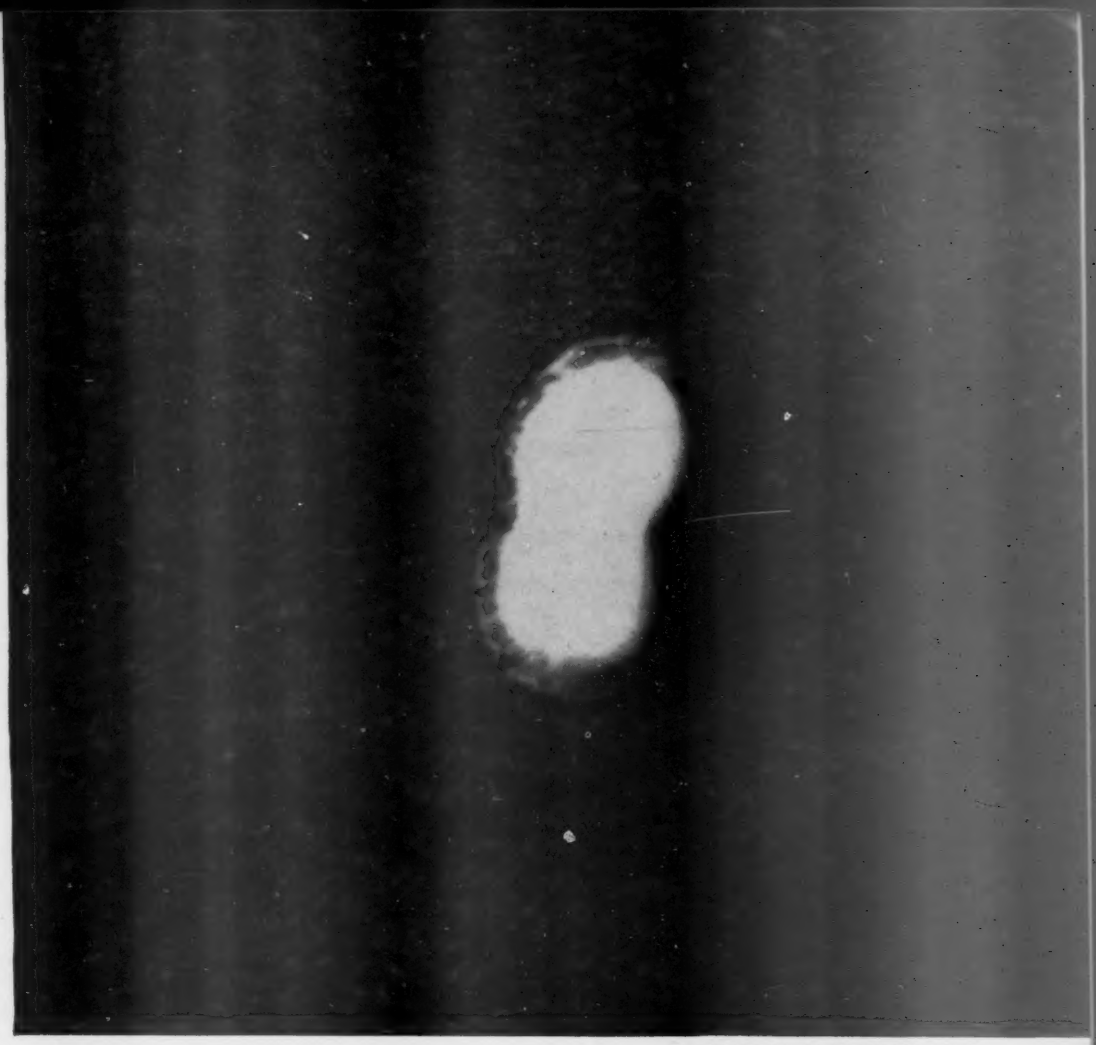
12:30—Luncheon and Round Table Discussion; Colorado and Centennial Rooms, Shirley-Savoy Hotel. Robert T. Porter, M.D., Greeley, President-elect, Colorado State Medical Society, presiding.

Question and Answer period conducted by Fred J. Hodges, M.D., Ann Arbor; James F. Rinehart, M.D., San Francisco; Richard W. Vilter, M.D., Cincinnati; Robert S. Sparkman, M. D., Dallas; Morris E. Dailey, M.D., San Francisco; Conrad Lam, M.D., Detroit; relating to Gastro-intestinal problems.

AFTERNOON

Lincoln Room of the Shirley-Savoy Hotel

Stuart W. Adler, M.D., Albuquerque, President-Elect, New Mexico Medical Society, presiding



ELECTRON PHOTOMICROGRAPH

Diplococcus pneumoniae 44,000 X

Diplococcus pneumoniae (Streptococcus pneumoniae) is a Gram-positive organism commonly involved in

lobar—and bronchopneumonia • chronic bronchitis • mastoiditis • sinusitis otitis media • and meningitis.

It is another of the more than 30 organisms susceptible to

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Symposium on Biliary and Pancreatic Problems

2:00—"Misconceptions in Gall Bladder Disease"—Robert S. Sparkman, M.D., Dallas.

2:20—"Chronic Relapsing Pancreatitis"—Morris E. Dailey, M.D., San Francisco.

2:40—"Radiological Diagnosis of Biliary Disease, Then and Now"—Fred J. Hodges, M.D., Ann Arbor.

3:00—Intermission to Study Exhibits.

3:30—All Exhibits Close.

3:30—"Surgical Aspects of Portal Hypertension"—Conrad Lam, M.D., Detroit.

3:50—"Patho-psysiological Relationship of Biliary and Pancreatic Disease"—James F. Rinehart, M.D., San Francisco.

Panel on Gastro-enterology — Moderator: Kenneth C. Sawyer, M.D., Denver.

4.10—Robert S. Sparkman, M.D., Dallas; Morris E. Dailey, M.D., San Francisco; Fred J. Hodges, M.D., Ann Arbor; Conrad Lam, M.D., Detroit; James F. Rinehart, M.D., San Francisco.

5:00—Adjourn.

Obituaries

EDWARD P. HUMMEL

Dr. Hummel died October 19, 1954, of heart disease at his home in Sterling, Colorado. He was born in 1893 on a farm near Waterloo, Iowa, and received his early education in Iowa. After attending business college in Pennsylvania, he returned to Iowa to teach school for two years. Then he went to Chicago to enroll as a student at the College of Physicians and Surgeons, from which instituton he received his M.D. in 1900. Following his licensure in Iowa, he practiced there for sixteen years, after which he did graduate work at the Eye, Ear, Nose and Throat College in Chicago.

In 1917, Dr. Hummel moved to Sterling, Colorado, where he practiced until his death. He served as Vice President of the Colorado State Medical Society; as President of the Northeast Colorado Medical Society, and as chairman of that Society's Board of Counselors for the year of 1941.

Dr. Hummel was very active in the religious and community life in Sterling. He is survived by his widow, Theoda, of 108 North Third Street, Sterling, and by three daughters.

EDWIN G. FABER

Dr. Edwin G. Faber died at his home in Tyler, Texas, December 8, 1954. A native of Colorado and a longtime Denver resident and physician, Dr. Faber was a graduate of Colorado College and Colorado University Medical School. He held a wide practice in Denver and was a member of the staffs of most of the Denver hospitals before moving to Tyler, Texas, fifteen years ago. He served in Europe as a Medical Corps colonel during World War II.

Dr. Faber is survived by his widow, Louise, and son, John, both of Tyler.

LORENZ WILLIAM FRANK

Dr. Lorenz Frank died suddenly at his home on November 18, 1954. He was born in 1887 at Kewanee, Illinois, and received his early education in Illinois. In 1911 he received his M.D. from the University of Nebraska Medical School and came on to Denver to intern at St. Luke's Hospital. He had practiced in Denver for many years, specializing in Internal Medicine, with special interest in diseases of the chest.

Dr. Frank was a member of the American Medical Association, Colorado State Medical Society and Denver Medical Society. He also belonged to the Clinical and Pathological Society of Denver, the American College of Physicians, the American Trudeau Society, the American College of Chest Physicians, and was a diplomate of the American Board of Internal Medicine.

Dr. Frank is survived by his widow, Mira, of 122 Albion Street; a son, Dr. I. Scott Frank, and a daughter, Mrs. Harriett Post; three brothers, three sisters, and six grandchildren.

ELI ABRAHAM MILLER

Dr. Eli Miller died November 9, 1954, at his home in Denver of a heart condition. He had been retired for some five years from active practice.

Dr. Miller was born in Denver in 1896 and received his education in Colorado, graduating from the Colorado Medical School in 1919. He practiced medicine in Denver for thirty-five years and was a frequent contributer to state and national medical journals.

Dr. Miller was a member of the American Medical Association, the Colorado State Medical Society and the Denver Component Medical Society. He was a leader in organizing and supporting the Beth Israel hospital and home for the aged. He was a former President of the B.M.H. synagog and was active in many other religious organizations.

Dr. Miller is survived by his widow, Mayme, of 798 Josephine; two sons, Dr. Gerald Miller and Irwin Miller; two daughters, Mrs. Barbara Pluss and Mrs. Annette Davidson; five brothers, Jake Miller, Dr. Lewis Miller, Hyman Miller, Israel Miller and Ben Miller, all of Denver.

ALDEN D. CATTERSON

Dr. Alden Catterson of 1067 Gilpin Street died October 17, 1954. He was born in 1872 in Moscow, Pennsylvania, and received his education in Pennsylvania, receiving his M.D. degree from the Medico-Chirugical College of Philadelphia in 1899. In 1909, he was licensed to practice in Colorado and located in Englewood where he specialized in Obstetrics and Gynecology. He was an honorary and an emeritus life member of the Colorado State Medical Society.

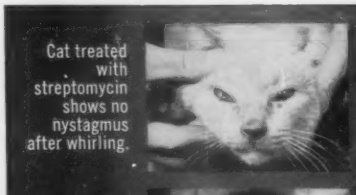
for greater safety in streptomycin therapy...

DISTRYCIN

Squibb Streptoduocin
Streptomycin and dihydrostreptomycin in equal parts

Distrycin has an important advantage over streptomycin. It has the same therapeutic effect but ototoxicity is greatly delayed. Since the patient is given only half as much of each form of streptomycin as he would have on a comparable regimen of either one prescribed separately, the danger of vestibular damage (from streptomycin) or cochlear damage (from dihydrostreptomycin) is significantly lessened.

Signs of vestibular damage appear in cats treated with Distrycin as much as 100 per cent later than in animals given the same amount of streptomycin.



Cat treated with streptomycin shows no nystagmus after whirling.

Cat given the same amount of Distrycin has normal reflex.

On dosage of 1 Gm. per day for 120 days, ototoxicity was as follows*:

	Vestibular damage % of patients		
	Mild	*Moderate*	*Total*
Streptomycin	12	6	18
Dihydrostreptomycin	6	0	6
Distrycin	0	0	0

	Cochlear damage % of patients		
	Mild	*Moderate*	*Total*
Streptomycin	0	0	0
Dihydrostreptomycin	12	3	15
Distrycin	0	0	0

**Heck, W.E.; Lynch, W.J., and Graves, H.L.: Acta oto-laryng. 43:416, 1953*

Distrycin dosage is the same as for streptomycin. In tuberculosis the routine dose is 1 Gm. twice weekly, in conjunction with daily para-aminosalicylic acid or Nydrazid (isoniazid). In the more serious forms of tuberculosis, Distrycin may be given daily, at least until the infection has been brought under control.

SQUIBB

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Distrycin is supplied in 1 and 5 Gm. vials, expressed as base

MEDICAL SPOKESMEN

Authorized to Speak for the Medical Societies in Colorado, for Publication and Broadcast Under Code of Cooperation

The officials of the Colorado State Medical Society and of its component societies as listed below are authorized by the profession to speak for their organizations when called by newspaper or radio and TV staff members with regard to medical news. They are the official spokesmen and they may be quoted. Publicity Chairmen are the primary liaison between medical societies, and press and radio and TV are expected to cooperate in matters pertaining to medical news.

STATE:

COLORADO STATE MEDICAL SOCIETY: 835 Republic Building, Denver 2. Telephone: AComa 2-0547. In the the event you cannot obtain the information desired through AComa 2-0547, the following State Society officials and lay staff members are available:

Dr. Samuel P. Newman, President, FLorida 5-4449.
Dr. Robert T. Porter, President-elect, Greeley 147.
Dr. John S. Bouslog, Publicity Chairman, KEystone 4-2301.
Dr. Gatewood C. Milligan, Chairman, Public Policy Committee, SUnset 1-4427.
Mr. Harvey T. Sethman, Executive Secretary, FRemont 7-0870.
Mrs. Geraldine Blackburn, Executive Assistant, SKyline 6-2467.

DENVER MEDICAL SOCIETY: 1601 East 19th Avenue, Denver 18. Telephone AComa 2-5817. (This number is also a 24-hour service for emergency calls for doctors and for information on general practitioners and specialists and for general information on health and medical services in Denver metropolitan area. Ask for Mrs. Lorene Davoren).

Dr. Bradford Murphy, President, KEystone 4-7787.
Dr. Samuel B. Childs, Secretary, FLorida 5-1671.
Dr. William B. Condon, Public Relations Chairman, ALpine 5-2889.

OUTSTATE:

Some local medical societies include only one county while others embrace two or more counties. In the listing below if additional counties are involved they appear in lower case. For brevity we have omitted "Medical Society" from the name of each and it should be added for the full title.

Medical Society	President	Secretary	Publicity Chairman
"ARAPAHOE COUNTY . . ." Douglas, Elbert	Wilbur D. Wood Littleton Blvd. at Lincoln, Littleton	P. B. Miner 3082 S. Broadway Englewood	Gatewood C. Milligan 3082 S. Broadway Englewood
"BOULDER COUNTY . . ."	C. C. Wiley 351 Coffman Longmont	B. A. Yost 323 Coffman Longmont	C. O. Roberts 1760 Sunset Boulder
"CHAFFEE COUNTY . . ." Gunnison, Park, Hinsdale	E. C. Budd 109½ E. 1st St. Salida	Stephen B. Phillips 415 E. 1st St. Salida	Stephen B. Phillips 415 E. 1st St. Salida
"CLEAR CREEK VALLEY . . ." Jefferson, Gilpin, Clear Creek	Lloyd H. Goad 819 13th St. Golden	Jerome D. Textor Lutheran Sanatorium Wheatridge	
"DELTA COUNTY . . ."	Jess Humphries 361 Palmer Delta	Robert Warner 748 Grand Delta	R. A. Underwood 327 Meeker Delta
"DENVER . . ." Adams	Bradford Murphey 814 Republic Bldg. Denver 2.	Samuel B. Childs 1624 Gilpin Denver 18	William B. Condon 1104 Republic Bldg. Denver 2.
"EASTERN COLORADO . . ." Kit Carson, Lincoln, Cheyenne	R. C. Beethe Wilson Building Burlington	J. O. Clanin Limon	L. N. Myers Fenner Ave. and 3rd Cheyenne Wells
"EL PASO COUNTY . . ." Teller	Harry C. Bryan 218 E. Willamette Ave. Colorado Springs	Edward H. Vincent 328 Burns Bldg. Colorado Springs	D. MacCorquodale 830 N. Tejon Colorado Springs

Medical Society	President	Secretary	Publicity Chairman
"FREMONT COUNTY . . ." Custer	Neill B. McGrath, Jr. 101 West Main St. Florence	Kon Wyatt, Sr. 215 N. 5th St. Canon City	Kon Wyatt, Sr. 215 N. 5th St. Canon City
"GARFIELD COUNTY . . ." Eagle, Pitkin, Rio Blanco	Virgil Gould Meeker	E. E. Mueller Glenwood Springs	Robert Livingston Glenwood Springs
"HUERFANO COUNTY . . ."	N. S. Saliba 119 E. 5th St. Walsenburg	James M. Lamme, Jr. 104 E. 7th St. Walsenburg	W. S. Chapman 136 E. 5th St. Walsenburg
"LAKE COUNTY . . ." Summit	George Stanley Gilman	John M. Kehoe 147 6th St. Leadville	
"LARIMER COUNTY . . ."	George Brown 125 So. College Ave. Fort Collins	Clarence Hilliard 605 S. College Ave. Fort Collins	F. A. Humphrey 115 S. College Ave. Fort Collins
"LAS ANIMAS COUNTY . . ."	Ben B. Beshoar 304 N. Commercial Trinidad	David R. Barglow 312 E. Main St. Trinidad	David R. Barglow 312 E. Main St. Trinidad
"MESA COUNTY . . ."	Kenneth E. Prescott 1115 Main St. Grand Junction	H. R. Bull 10 Med. Arts Bldg. Grand Junction	T. K. Mahan 2232 N. 7th Grand Junction
"MONTROSE COUNTY . . ." San Miguel, Ouray	Lloyd K. Rosenvold 700 Main St. Montrose	Thomas O. Plummer Nye Bldg. Montrose	Roy F. Carpenter 732 Main Street Montrose
"MORGAN COUNTY . . ."	James Price Farmers State Bank Building, Brush	W. Ham Jackson 512 Prospect Ave. Fort Morgan	W. Ham Jackson 512 Prospect Ave. Fort Morgan
"NORTHEAST COLO. . . ." Logan, Phillips, Sedgwick	Carl J. Manganaro 1165 4th St. Sterling	R. J. Groeger 201 S. 4th St. Sterling	
"NORTHWESTERN COLO. . . ." Grand, Moffat, Routt, Jackson	Hugh S. Richards 525 Lincoln Ave. Steamboat Springs	James B. Horne Hayden	
"OTERO COUNTY . . ." Bent, Crowley	W. R. Sisson 111 W. 2nd St. La Junta	Elmer L. Morgan 913 Elm Rocky Ford	
"PROWERS COUNTY . . ." Baca, Kiowa	K. F. Krausnick 200 S. 5th St. Lamar	G. S. Williams 409 S. Main St. Lamar	Lanning E. Likes 800 S. Main St. Lamar
"PUEBLO COUNTY . . ."	F. G. Tice, Jr. 416 Court Place Pueblo	J. S. Clutter 702 N. Main Pueblo	Eugene B. Ley 412 Colorado Bldg. Pueblo
"SAN JUAN BASIN . . ." Archuelta, Delores, La Plata, Montezuma, San Juan	E. G. Merritt 507 Main St. Dolores	Robert B. Perry 777 Main Durango	
"SAN LUIS VALLEY . . ." Alamosa, Conejos, Costilla, Mineral, Rio Grande, Saguache	Ernst Wittenberg La Jara	Robert B. Bradshaw 810 Main St. Alamosa	V. V. Anderson 825 6th St. Del Norte
"WASHINGTON-YUMA COUNTIES . . ."	J. G. Hedrick 517 Adams Wray	W. G. Thompson 517 Adams Wray	G. T. Good Medical Arts Bldg. Yuma
"WELD COUNTY . . ."	A. E. Peterson 218 Greeley Bldg. Greeley	J. J. Zuidema 1801 17th St. Greeley	E. P. Montgomery 1648 8th Ave. Greeley

Jewish Anniversary Medical Clinics

As part of the 300th anniversary of the arrival of the first Jews in America, the Jewish physicians of Denver in cooperation with General Rose Memorial Hospital, the National Jewish Hospital and the J.C.R.S. Sanitarium will conduct a three-day clinical meeting, January 10, 11 and 12.

In 1654, the first Jews migrated to America to what was then New Amsterdam. Since that time, Jews have become a part of their communities in every field of endeavor. Medicine has been no exception; for here, too, physicians of the Jewish faith have had the opportunity to contribute along with their confreres of other faiths, contributing to American medicine.

Five nationally known specialists will participate in the Clinics as guest speakers. These will include the following:

John H. Garlock, M.D., Clinical Professor of Surgery, Columbia University, and Senior Surgeon, Mount Sinai Hospital, New York City. Dr. Garlock is the immedate Past-President of the New York Medical Society and is one of the Founder Members of the American Board of Surgery, the American Board of Plastic Surgery and the American Board of Thoracic Surgery.

Harry H. Gordon, M.D., Pediatrician-in-Chief, Sinai Hospital of Baltimore, and Associate Professor of Pediatrics, Johns Hopkins Medical School. Dr. Gordon will be remembered as Head of the Department of Pediatrics at the University of Colorado School of Medicine from 1946 to 1951.

Earle I. Greene, M.D., Professor and Co-Chairman of the Department of Surgery, Chicago Medical School, and Professor of Surgery at the Cook County Post-Graduate School, Cook County Hospital, Chicago.

Laurence F. Greene, M.D., Consultant in Urology, Mayo Clinic; Associate Professor of Urology, Mayo Foundation and University of Minnesota Graduate School; and Consulting Urologist, Methodist Hospital, Rochester, Minnesota.

Isidore Snapper, M.D., Director of the Department of Medicine and Medical Education, Beth-El Hospital, Brooklyn, and former Clinical Professor of Medicine, Columbia University, New York City.

There will be advance registration in the lobby of General Rose Hospital on Sunday, January 9, from 2:00 to 4:00 p.m. There is no registration fee for the Clinics and all events in connection with the meetings will be free of charge.

The Clinics will open with registration at 8:00 a.m., Monday, January 10, at General Rose Hospital and clinical programs will be conducted simultaneously at the Rose Hospital, National

Jewish Hospital and J.C.R.S. throughout the morning. A Round Table Luncheon will be held at J.C.R.S. The afternoon programs will be conducted at the Sabin Amphitheater of the University of Colorado School of Medicine and at the Veterans Administration Hospital. Similar simultaneous clinics will be conducted at the various hospitals Tuesday morning and Wednesday morning, but both afternoons will be left free. A Tuesday Round Table Luncheon will be held at National Jewish Hospital. Wednesday evening the program will close with a joint dinner with the staff of Denver General Hospital.

REPORT OF DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

The Eighth Clinical Meeting of the American Medical Association was held in Miami, Florida, November 29 to December 2, 1954. Registered were 3,253 physicians, 3,441 guests, appromixately 900 exhibitors and guests, a total registration of 7,707. There were twenty-seven registered from Colorado.

A concise summary of the proceedings of the House of Delegates was made by Dr. George F. Lull, Secretary and General Manager, from which report we quote, in part:

Geriatrics, medical ethics, internships, grievance committees, hospital accreditation, osteopathy, the doctor draft law, state-subsidized medicine and malpractice insurance problems were among the major subjects of discussion and action by the House of Delegates at the American Medical Association's Eighth Clinical Meeting.

During the meeting the A.M.A. Board of Trustees announced the appointment of a thirteen-member commission to make a comprehensive survey of the various types of plans through which the American people receive medical services.

The opening session was addressed by President Walter Martin; Mr. Seaborn P. Collins, National Commander of the American Legion; Mrs. Oveta Culp Hobby, Secretary of Health Education and Welfare, and Mr. Edwin J. Faulkner, President of the Woodmen Accident and Life Company of Lincoln, Nebraaska.

Mr. Collins, speaking for the American Legion, stated that he is willing to appoint qualified Legion representatives on a committee to take part in joint Legion-A.M.A. study of veterans' hospitalization. The American Legion, he declared, neither expects nor wants the Government to give carte blanche entitlement to medical care to all veterans. The Board of Trustees announced the appointment of a three-man committee to meet with the Legion committee on the issue of veterans' medical care. The members of the A.M.A. committee are Dr. Elmer Hess, Dr. David Allman and Dr. Louis Orr.

New A.M.A. Geriatrics Unit

The House of Delegates passed a Pennsylvania resolution which directed that the A.M.A. Board of Trustees "consider the creation of an organization on geriatrics within the present structure of the American Medical Association, the purpose of which shall be (1) to develop and assist committees on geriatrics and gerontology originating from constituent state associations and component county societies of the American Medical Association; (2) to act as liaison between such state and county committees so there shall be a free flow of information between all levels of organized medicine on the subject of geriatrics; (3) to make available to the American people such facts, data and opinions concerning the subject of geriatrics as may be considered of value in alleviating social and medical problems created by the increasing population of older age groups, and (4) to perform such other duties as will improve and advance the medical care rendered to people of the older age group."

Medical Ethics

Accepting a recommendation in a report of the Council on Constitution and By-Laws, the House amended Section 7 of Chapter I of the Principles of Medical Ethics so that it now reads as follows on the subject of patents and copyrights:

"A physician may patent surgical instruments, appliances and medicines or copyright publications, methods and procedures. The use of such patents or copyrights or the receipt of remuneration from them which retards or inhibits research or restricts the benefits derivable therefrom is unethical."

Report on Internships

Acting on the report of the Ad Hoc Committee on Internships, the House accepted a recommendation of the Reference Committee on Medical Education and Hospitals that "the data and judgments of the Ad Hoc Committee on Internships will provide valuable guidance to the Council on Medical Education and Hospitals and with this in view it is recommended that the report be referred to the latter for their further study and guidance." Following are a few excerpts from the report of the Ad Hoc Committee on Internships:

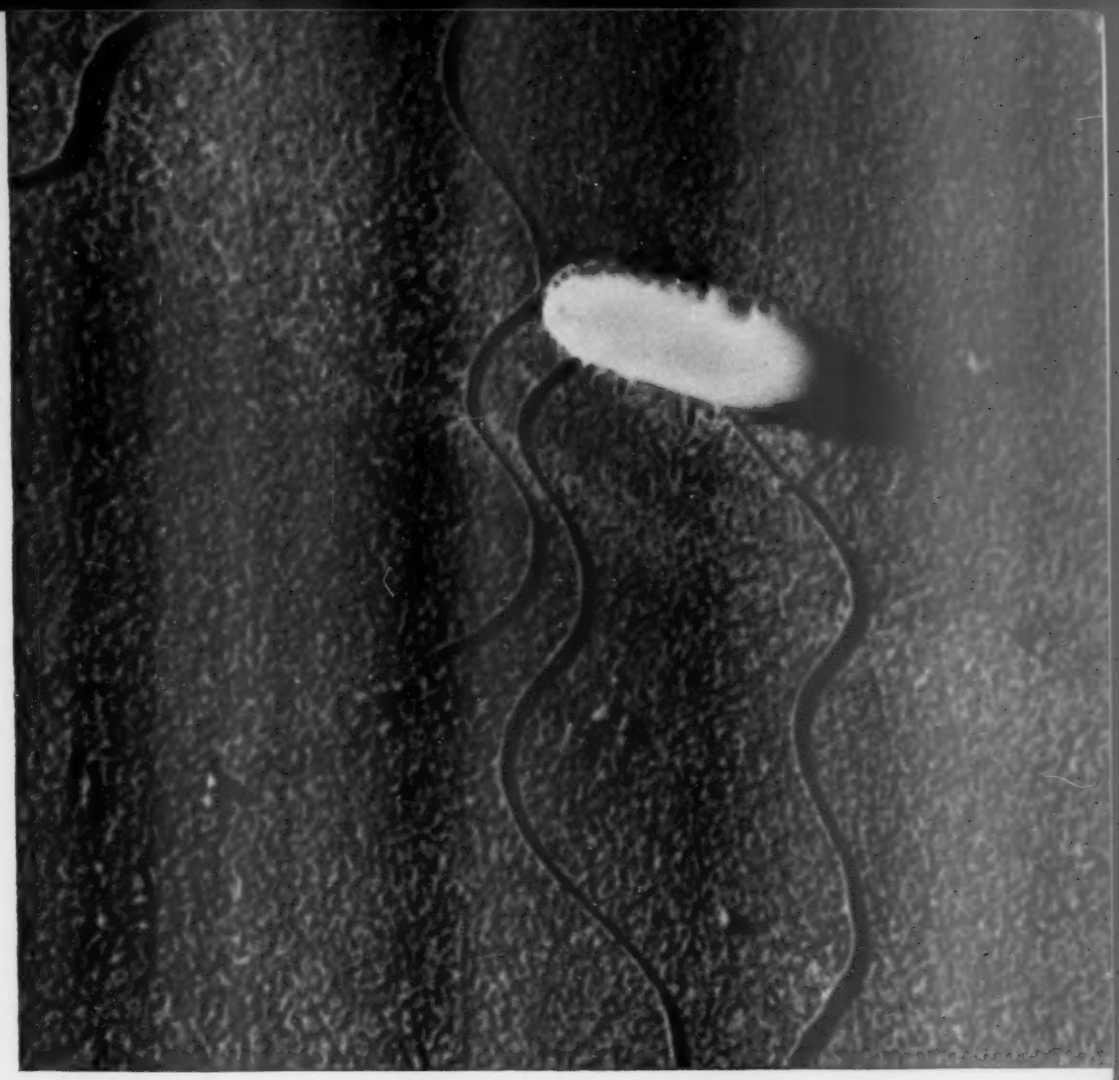
"It is our opinion that graduates of foreign medical schools should be considered for intern appointment in approved hospitals only when there is satisfactory evidence that:

"1. Language difficulties will not seriously impair the program.

"2. The same educational standards are applied to graduates of foreign schools as to graduates of approved American medical colleges.

"3. The appropriate state licensing board approves. . . .

"The committee believes that the present standards detailing only the number of annual



ELECTRON PHOTOMICROGRAPH

Salmonella paratyphi B 32,000 X

Salmonella paratyphi B (Salmonella schottmuelleri) is a

Gram-negative organism which causes

food poisoning • chronic enteritis • septicemia.

It is another of the more than 30 organisms susceptible to

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admissions, autopsy rate, number of beds and assignment of an intern to from fifteen to twenty-five beds, are without significant meaning unless and until every local situation is reviewed 'on the grounds' and with full opportunity for discussion between the representative of the accrediting body and representatives of the hospital's governing board and its medical staff. . . .

"Had the 'two-thirds' remained a requirement and been rigidly applied to the two consecutive intern years 1952-53 in combination with 1953-54 it would have removed 448 hospitals, cancelled 4,205 internships to which 784 students were matched in those years and reduced the number of internships available to 6,766. . . .

"The committee suggests consideration of some requirement based on filling a percentage of approved internships and a time limit to eliminate some of the unhealthy aspects of the present situation. The following requirement is recommended: Any internship program which in two successive years does not obtain one-fourth of its stated intern complement be disapproved for internship training.

"As applied to the figures for 1952-53 in combination with 1953-54, this requirement would have removed 277 hospitals, cancelled 2,139 internships to which eighty students were matched in those years and reduced the number of internships available to 8,832."

Grievance Committees

In order to improve efficiency and maintain high standards in the operation of grievance or mediation committees, the House endorsed the principles of two similar resolutions introduced by the Colorado and Mississippi delegations and asked the Board of Trustees to appoint a committee to study and report on recommended standards for the operation of such services. Both resolutions had emphasized the valuable public service aspects of grievance committees and had suggested that the committee appointed by the Board of Trustees be composed of representatives from constituent societies in which grievance committees have been effective and useful.

Hospital Accreditation

In place of an Indiana resolution protesting certain situations arising in connection with hospital inspections, the House adopted the following substitute resolution to resolve the problems in question:

"Resolved, that the Secretary of the American Medical Association be directed to request that the Joint Commission on the Accreditation of Hospitals supply a copy of the letter of notification regarding the results of the survey of each hospital to the Hospital Administrator, to the Chief of the Professional Staff and to the Chairman of the Governing Board of the hospital."

Osteopathy

The House concurred in the following supplementary report of the Board of Trustees on the osteopathic situation:

"Contingent on the receipt of the report from the Committee to Study the Relations Between Osteopathy and Medicine of its 'on campus' observations of osteopathic schools, the House of Delegates in June, 1954, agreed to hold in abeyance any action on this important subject until this meeting.

"The committee, after meetings and extensive negotiations with the American Osteopathic Association, has now made final arrangements for visiting five of the six schools of osteopathy, and these plans have been approved by the Board of Trustees.

"It is the recommendation of the Board, therefore, that consideration of this matter be held in abeyance by the House of Delegates until the June, 1955, meeting, at which time the committee expects to have a complete report of its findings concerning the nature, scope and quality of education in schools of osteopathy."

The Doctor Draft Law

The Reference Committee on Medical Military Affairs considered several reports and resolutions involving the doctor draft law, and then proposed the following policy statement which was adopted by the House of Delegates:

"(A) That on the basis of current information the House of Delegates commend and express itself as being in complete accord with the Board of Trustees and its Council on National Defense that the 'Doctor Draft Law' should not be extended after June 30, 1955, and that the House of Delegates further express its confidence in the ability of the Board of Trustees and its Council on National Defense to properly handle any new situation which may develop in regard to this highly complex and involved problem.

"(B) That the Board of Trustees and its Council on National Defense continue to study the problem of providing the best possible medical service for members of the armed forces and that they make recommendations to the Department of Defense at the earliest possible time for a more permanent solution to the problem, giving special attention to the further development of a career medical corps with adequate compensation therefor."

State-Subsidized Medicine

Most controversial issue at the Miami meeting was a resolution on "Policy on Medical Practice by Tax Supported Medical Schools," introduced by the Mississippi State Medical Association. This resolution provided that:

"The American Medical Association reaffirm its unalterable opposition to socialized and state subsidized medicine regardless of the form which it may assume, and

When you
select an
antibacterial —

...you may wonder which one to prescribe. We believe you'll agree that most of them are rather good. Still, we suggest you try Gantrisin 'Roche'...because this single sulfonamide is soluble in both acid and alkaline urine...because it has a wide antibacterial spectrum...an impressive clinical background...and, above all, because it's so well tolerated by most patients. Gantrisin® -- brand of sulfisoxazole.

These are the Gantrisin advantages —

Gantrisin 'Roche' is a single, soluble, wide-spectrum sulfonamide -- especially soluble at the pH of the kidneys. That's why it is so well tolerated...little danger of renal blocking...does not require alkalies. Produces high plasma as well as high urine levels. Over 250 references to Gantrisin® in recent literature.

"The House of Delegates of the American Medical Association is of the opinion that these principles should be considered by constituent and component medical societies, together with all other facts pertinent to the local situation, in all controversies arising in the employment of medical faculty by state (tax) supported medical schools and be fully considered in effecting action within the framework of this policy."

The Reference Committee on Medical Education and Hospitals agreed with that portion of the resolution regarding "unalterable opposition to socialized medicine" but recommended that the resolution be referred, without approval or disapproval at this time, to the Council on Medical Service which currently is studying the various aspects of this subject. The House adopted the reference committee's recommendation.

Malpractice Insurance

Two resolutions and a Board of Trustees supplementary report—all dealing with the problems and difficulties in obtaining satisfactory professional liability insurance—were considered together by the Reference Committee on Insurance and Medical Service. The House of Delegates accepted the reference committee report which said: "Inasmuch as the Board of Trustees has reported that there is in progress a study on the subject, we feel that we can well await the recommendations that the Board is planning to make at the next session. Due to the apparent emergency aspect of the problem, the Board of Trustees is urged to report to the membership as soon as possible, through its component societies, on the progress of this urgent study."

Opening Session

Dr. Walter B. Martin, A.M.A. President, declared at the opening session that "medicine belongs to the people" and physicians are "merely the purveyors" of medical care. Dr. Martin stressed that physicians have an obligation to the people that "goes beyond our own private practice and into the community," and he also emphasized the importance of "continued effort to meet the medical needs of the low-income and other non-insurable groups."

Mrs. Hobby, presenting the case for the Eisenhower Administration's health reinsurance proposal, said: "The health reinsurance proposal represents what we believe to be a necessity. It offers opportunity for self-help without subsidy." Mr. Faulkner, however, expressed the opinion that the reinsurance program, "would be foredoomed to disappoint its proponents," and he declared that voluntary health insurance can bring satisfactory protection "to practically all of our people" without a Federal reinsurance program.

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— gives a zestful "salty" flavor to the sodium-restricted diet — helps to keep the patient on the salt-free regimen by making meals tasty.

Neocurtasal may be used wherever sodium restriction is indicated — it is completely sodium-free. May be used like ordinary table salt — added to foods during or before cooking or used to season foods at the table.

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"... trustworthy non-sodium containing salt substitute"[1]

Write for pad of diet sheets.

Supplied in 2 oz. shakers and 8 oz. bottles.

1. Heller, E. M.: The Treatment of Essential Hypertension. *Canad. Med. Assn. Jour.*, 61:293, Sept., 1949.

CONSTITUENTS: Potassium chloride, ammonium chloride, potassium formate, calcium formate, magnesium citrate, potassium iodide (0.01%) and starch.

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Awards and Contributions

At the closing session of the House of Delegates the American Medical Association received a citation for pioneering in helping to bring educational television to the American public. James Keller, chairman of the Miami Citizens Committee for Educational Television, presented the award on behalf of the National Citizens Committee for Educational Television. Dr. Martin accepted the citation for the A.M.A.

1957 Clinical Meeting

Philadelphia was chosen as the place for the 1957 Clinical Meeting, the dates of which will be announced later. Invitations also had been received from Denver, Detroit, Mexico City and Washington, D. C. The Clinical Meeting will be held in Boston in 1955 and in Seattle in 1956.

Health Fair

As the A.M.A. Clinical Meeting came to a close on Thursday, December 2, a health fair for the public opened in Miami's Bayfront Auditorium under the auspices of the Dade County Medicial Society. The fair, to be open through Sunday with more than eighty exhibits featured, marks the first time that such an event has been held in connection with the A.M.A. Clinical Meeting.

Additionally, we desire to add:

Dr. Karl B. Pace of Greenville, North Carolina, was selected as General Practitioner of the year 1954.

Thirty-two resolutions were introduced and acted upon. A resolution introduced by Dr. R. M. McKeown of Oregon deserves attentive study. "Resolved: That the Board of Trustees be authorized and directed to reactivate, at least on a limited basis, the essential machinery utilized in the National Education Campaign." The Colorado resolutions on Grievance Committees and protective insurance rates were approved by the Reference Committee and by the House.

In the matter of deleting the word "Rehabilitation" from the titles of the American Board and from the Section and Council on Physical Medicine and Rehabilitation, the Board of Trustees requested that the special committee considering it be continued with the expectation of submitting a full report in June, 1955.

In an informal address, Dr. Louis H. Bauer, President of the American Medical Education Foundation, reported that the Board of Trustees had allocated $100,000 to the Foundation. He emphasized the advisability, even the necessity, of physicians contributing to this activity and estimated that if each member of the A.M.A. would donate $30.00, annually, the aggregrate sum would amount to about one-half of the needs of the Foundation. The Utah State Medical Society presented $10,355.00 to the Foundation, derived from an assessment added to Utah State dues. Of interest is a recent news report that the Standard Oil Co. of New Jersey donated $50,000.00 to the National Fund for Medical Education. The Seventh Public Relations Conference was held on November 28, 1954. It was well attended. At the morning session Mr. Leo E. Brown, Director of Public Relations for the A.M.A., presented a resume of a new manual for County Medical Societies, emphasizing "The Basic Eight," Public Relations activities. This is a manual of procedure for initiating and implementing better public relations. It is well planned and comprehensive. It will be available to county societies through the office of the Executive Secretary. The afternoon session was devoted to panel discussions of business administration in the physician's office and to Veteran's Affairs.

The scientific sessions and exhibits were outstanding and well attended. The Proceedings of the House of Delegates will be published in early issues of the Journal A.M.A. It is hoped that all members will read them fully.

Hospitality of the Florida Medical Association, of the Dade County Medical Association, and of the gracious ladies of the Auxiliary was the subject of much favorable comment, and was deeply appreciated. When in Florida or in California, a visitor is obligated to discuss the climate, the oranges, the grapefruit, the fish and fishing. One observer from the high mountains could not, when he closed his eyes, decide which of these wonderful states he was enjoying. However, there is a difference: Florida has NO smog and California has NO lime pie.

GEORGE A. UNFUG, M.D.
WILLIAM H. HALLEY, M.D.

SAFEGUARDING THE WORKER'S HEALTH

Building an effective health program for American industry, utilizing the facilities of medicine, government, management and labor, will be emphasized at the Fifteenth Annual Congress on Industrial Health. Sponsored by A.M.A.'s Council on Industrial Health, the Congress will be held January 25 and 26 at the Shoreham Hotel, Washington, D. C.

Following the general theme—"Goals of Preventive Medicine"—panel discussions will be presented on: (1) Industrial health as a major component in community health; (2) Training and recruitment of qualified professional personnel; (3) Medical care plans; (4) Workmen's compensation and rehabilitation, and (5) Health in the atomic age, stressing the need for modern protective methods of safeguarding the worker's health.

A pre-conference session for medical society committee members will be held January 24 to consider problems of special interest to the medical profession.

Wyoming

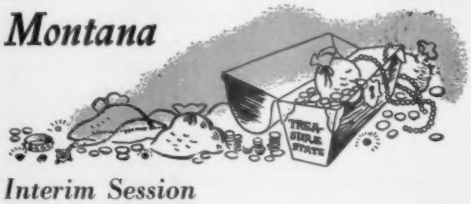
MISSING PHYSICIAN FOUND DEAD

Henry H. Hall, M.D., from St. Paul, Minnesota, aged 73, was found dead south of Upton, Wyoming, on May 5, 1954. Dr. Hall was a graduate of the Minnesota College of Physicians and Surgeons in 1908, and was licensed in Minnesota in 1925.

It will be recalled that in May, 1953, he was reported missing en route from St. Paul to the home of his daughter who resides in Denver. His car was discovered out of gas near the Pat Nolan ranch but despite search from the air and the ground, no clue was found as to the whereabouts of Dr. Hall.

Rancher Jimmie Norris of Upton found the body on May 5 of this year, three-fourths of a mile east of where the car had been stalled the previous spring. The death certificate filed by Dr. E. J. Guilfoyle, Weston County Health Officer, stated cause of death "unknown, probably exposure," and this discounted the theory at the time of the hunt that he had met with foul play because of having once treated and testified against members of the Karpis-Barker kidnap gang.

Montana



Interim Session To Feature Clinics

The Eighth Interim Session of the Montana Medical Association will be held in Helena, March 11-12, 1955. Scientific sessions will be held on the first day of the meeting, Friday, March 11; administrative sessions will be held on Saturday, March 12. The Program Committee, under the chairmanship of John A. Layne, M.D., of Great Falls, plans an entirely different type of meeting than has been held previously and a rather unusual one. The 1955 Interim Session will be a clinical meeting, using the facilities of the Veterans Administration Hospital at Fort Harrison. The scientific program will feature "wet clinics" or actual clinical demonstrations of many surgical and medical procedures. Luncheon will be served at the VA Hospital so it will not be necessary to recess during the noon hours.

National Affairs

A.M.A. BACKED 11 OF 15 NEW NATIONAL LAWS

Too many persons, even some within the medical profession, have the impression that the American Medical Association and its constituent and component societies are always "against" proposed legislation and never "for" anything.

It is high time that, as Al Smith used to say, we "look at the record."

Fifteen major medical and allied-subject bills were enacted into law by the Eighty-third Congress. The A.M.A. supported eleven of them, took no position on two, and opposed two. The "record" is clearly given in an editorial which appeared in the December 4, 1954, issue of the Journal A.M.A. We reprint it here for any who missed it in the J.A.M.A.:

During the past year or more the American public has become aware of the fact that the American Medical Association opposed the federal reinsurance proposal, disapproved of two provisions in the Social Security Act amendments, and disagreed with the government policy on medical care for veterans with non-service-connected disabilities. Unfortunately, however, the public is not equally aware that during that same period of time the A.M.A. was giving active support to a large number of constructive legislative proposals involving medicine and health. We believe, therefore, that some long-overdue attention should be paid to the positive side of the record.

That record shows that the A.M.A. supported eleven of the fifteen major medical bills that were enacted into law by the Eighty-third Congress. The association opposed only two of the fifteen, and took no stand on the other two. The eleven proposals that the A.M.A. favored and which became public law were as follows:

Expansion of the Hill-Burton Hospital Construction Act to help finance the building of new nonprofit health facilities.

Extension of the regular Hill-Burton Act to 1960.

Lowering of the medical expense tax deduction from 5 per cent to 3 per cent.

Extension of the "Doctor-Draft" law to 1955.

Establishment of the Department of Health, Education, and Welfare.

Establishment of the Hoover Commission on Organization of the Executive Branch of the Government.

Establishment of the Commission on Intergovernmental Relations.

Transfer of the Indian Hospital and medical service from the Department of the Interior to the Public Health Service.

Ban against the shipment of fireworks into states where their sale is illegal.

A federal charter for the National Fund for Medical Education.

Permission for oral narcotic prescriptions under certain conditions and limitations.

In addition to those eleven measures, the A.M.A. also supported two major proposals that were not acted on by the Eighty-third Congress. These were the administration bill to streamline Public Health Service grants to the states and the Jenkins-Keogh bills to stimulate the establishment of private pension plans by self-employed persons and by employees without the protection of company plans.

We may be indulging in a bit of wishful thinking, but it would be helpful if the American people had more knowledge of the fact that the A.M.A. every year supports constructive legislation. The positive side of the story may not have blood-and-thunder news interest, but it spells out steady, continued progress in protecting the public health and welfare.

A.M.A. COUNCIL ON MEDICAL EDUCATION AND HOSPITALS PLANS CONFERENCE

The Council on Medical Education and Hospitals of the A.M.A. is planning a program on the subject of "The Potential Use of Television in Postgraduate Medical Education" to be presented as a full-day working conference on February 5, 1955, in the ballroom of the Palmer House, Chicago. This is expected to be the first of a series of annual "workshop" type conferences on one particular aspect of postgraduate medical education. Television is the subject of the first meeting because of the extreme interest in this medium that has been shown recently, as well as its pertinence to the future of postgraduate education. The program is planned in such a way as to present both the educational and technical aspects of the subject.

Following a keynote address by Dr. John Cline, the morning session will be devoted to considerations of the purely educational aspects of the medium. The afternoon session will deal with technical considerations and financing. The participants will be drawn from the fields of general education, television, industry, medicine, medical education, pertinent government agencies and others. It is planned to have a number of demonstrations in the afternoon session using actual camera chains and receiving equipment. Following the session it will be possible for the audience to examine these and observe some of them in further action, and visit a local television station in action.

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audivox presents a versatile new tool in the psychological and somatic management of hearing loss — the Model 72 "New World." Because it departs completely from conventional hearing-aid appearance, this tiny "prosthetic ear" may be worn as a barrette, tie clip, or clasp without concealment. Resultant benefits include new poise and new aural acuity for the wearer through free-field reception without clothing rustle.

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the thoroughbred hearing aid

*The Drug of Choice In Amebiasis**

The drugs that are in widest use in the treatment of amebiasis today are the following:

1. Antibiotics: Aureomycin, Terramycin and fumagillin.
2. Iodohydroxyquinolines: Diodoquin, Vioform and Chiniofon.
3. Arsenical: Carbarsone.
4. Bismuth-arsenic: Milibis.
5. 4-aminoquinoline: chloroquin.
6. Alkaloid: emetine.

The use of antibiotics began in 1949 when McVay and his colleagues discovered the usefulness of Aureomycin in amebiasis. At that time satisfactory but not total rates of cure had already been obtained with Carbarsone, Diodoquin, Vioform and Chiniofon. The effectiveness of antibiotics cannot be denied, but their limitations are equally apparent to the critical observer. For example, most physicians have observed side efects which are sometimes severe and surprisingly persistent following discontinuance of the drug.

The initial enthusiasm following the results of short-term study of these drugs was somewhat tempered as recurrences were detected among the patients followed for four or more months. With any drug used in treating amebiasis, a relapse rate of 10 or 20 per cent is usually found when cases are followed adequately.

The latest antiamebic product of the mold is fumagillin, which is amebicidal in vitro in extremely high dilution. It produces undesirable, although not serious, side effects, and the rate of cure is high, but not total.

How do the iodohydroxyquinolines compare with the antibiotics? Out of 152 adult patients treated with Diodoquin by the author, sixteen (11 per cent) showed positive stools at some time after treatment. Six of these sixteen cases, however, had inadequate doses of the drug. The cure rate with Diodoquin was, therefore, over 90 per cent in adults. Similar results were obtained with fifty-seven children. The author's impression is that Diodoquin is the most dependable of these quinoline compounds, and that Vioform is somewhat more effective than Chinofon.

The choice in any given case should be dictated by such considerations as previous failure of a given amebicide, history of sensitivity, severity of symptoms, presence of hepatitis, necessity for rapidity of treatment, certainty of diagnosis, and the financal status of the patient.

In choosing a drug one should not prescribe any of the "mycin" antibiotics for the patient who has a history of nausea, vomiting, diarrhea, abdominal pain, or anal pruritus following his previous use of that drug. For general use, Diodoquin is a good amebicide, and does not usually cause side efects. Milibis is a satisfactory general amebicide although the failure rate in children seems to be high. Treatment with Vioform results in a higher incidence of gastrointestinal symptoms. Fumagillin is a potent amebicide and its exact place in the scheme of treatment must await continued evaluation. Aureomycin and Terramycin are effective amebicides but their use is attended with a high incidence of undesirable side effects and they are expensive. Terramycin may be the more efficient of these two.

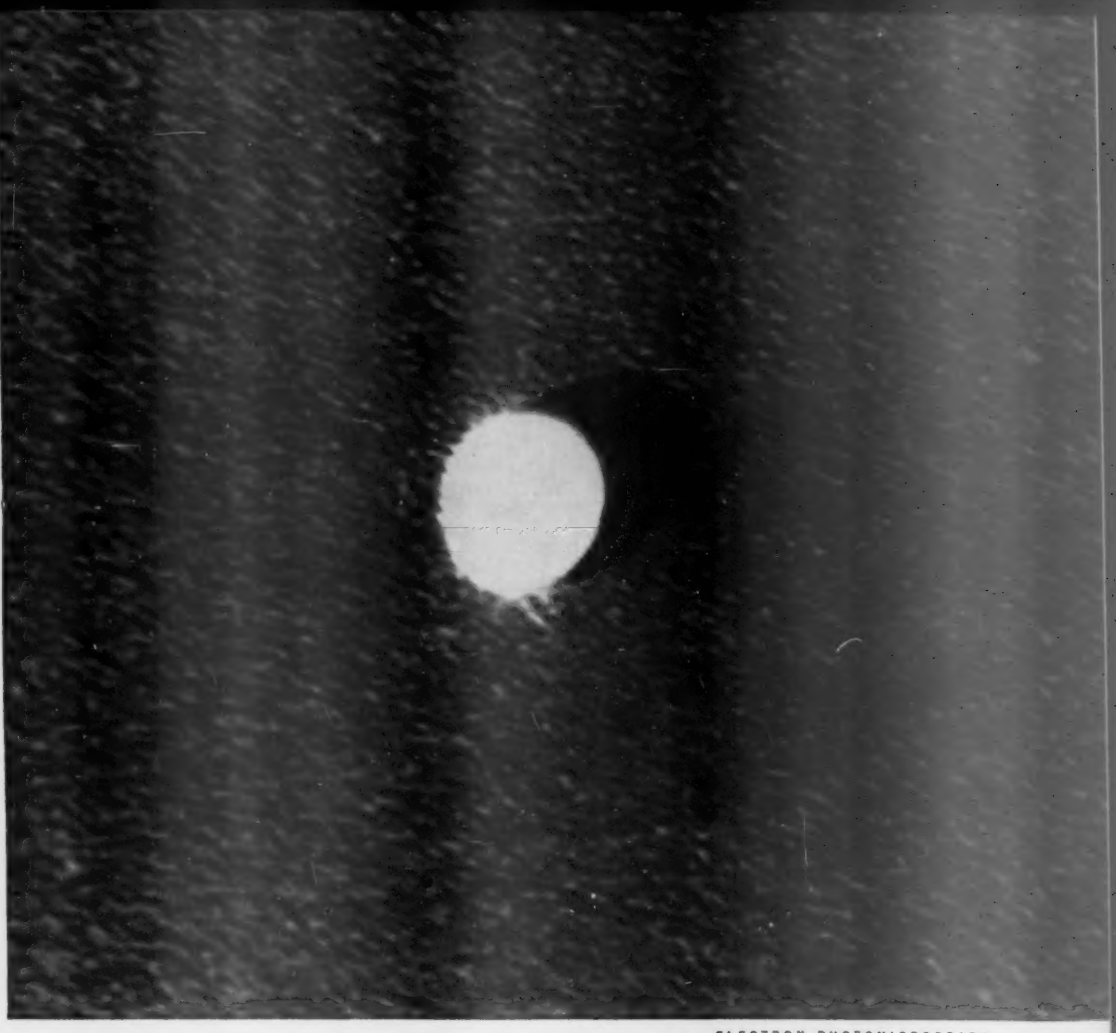
In broad perspective, perhaps most of the cases seen in this country will best be managed with a course of Diodoquin or Carbarsone. A certain number will do well on fumagillin, Terramycin or Aureomycin; or with penicillin or sulfasuxidine followed by Diodoquin in sicker patients; the seriously ill cases should be given emetine either before or concurrently with the standard amebicides.

For amebic hepatitis, chloroquin is employed. One of the standard drugs efficient against intestinal amebiasis should always be given concurrently or after completion of the course of chloroquin.

*Medical abstract from James F. Fleming, M.D., 30 West Washington Street, Chicago 2, Illinois. Author: K. G. Dwork. Amer. J. Gastroenterol, 22:152 (Aug.), 1954.

NEW CLOSED-CIRCUIT MEDICAL TV SHOW ANNOUNCED

"Videclinic"—a special closed-circuit television program to bring new advances in medicine to physicians quickly—will be presented coast to coast on February 9 by the American Medical Association. The telecast is expected to be viewed by nearly 18,000 doctors in at least thirty cities, the largest single closed-circuit television audience of its kind.



ELECTRON PHOTOMICROGRAPH

Staphylococcus aureus 44,000 X

Staphylococcus aureus (Micrococcus pyogenes var. aureus) is a Gram-positive organism commonly involved in a great variety of pathologic conditions, including

pyoderma • abscesses • empyema • otitis • sinusitis • septicemia

bronchopneumonia • bronchiectasis • tracheobronchitis • and food poisoning.

It is another of the more than 30 organisms susceptible to

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In making the announcement, Dr. George F. Lull said this program will bring the full array of modern television technics—live television, "remote pickups" from medical centers, and adequate film coverage—to the service of medical education for the first time.

The program will concern heart disease, a problem of increasing importance to our aging population.

Projected as the "Medical Journal of the Air," the new program will visually demonstrate new advances in medicine and will help bridge the gap between the time a scientific paper is presented at a medical meeting and the time it comes to the attention of the practicing physician through normal publication channels.

The program, presented by the American Medical Association in cooperation with Smith, Kline and French Laboratories, a Philadelphia pharmaceutical house, will be shown at 8:30 p.m. E.S.T., Wednesday, February 9. It will be telecast over the "Telesession" facilities of Theater Television, Inc., New York.

The following cities are tentatively scheduled to receive the "Videclinic" program: Boston, New York, Brooklyn, Detriot, Cincinnati, Chicago, Baltimore, Cleveland, Philadelphia, Pittsburgh, Providence, Washington, Indianapolis, Louisville, Albany, Troy, Schenectady, Buffalo, Dayton, Toledo, Youngstown, St. Louis, Milwaukee, Los Angeles, San Francisco, Houston, New Orleans, Atlanta, Dallas, Denver and Birmingham. Other cities may be added prior to telecasting time.

Notable Victory For Free Choice

A victory for free choice of physician was indicated at a meeting held November 17 with bargaining representatives of employee unions of Kennecott Copper Corporation, representatives of management for Kennecott, and a special committee of the Utah State Medical Association and the Salt Lake County Medical Society.

It was explained by management and the unions that they had departed from a plan of clinic medical care after more than twenty-five years, in favor of free choice of physician, under a policy written by a private insurance company. The policy covers 6,000 workers and their families.

The representatives asked cooperation in placing the plan into effect and suggested a liaison committee of the Utah State Medical Association. President Charles Ruggeri, Jr., then designated the Industrial Health Committee of U.S.M.A. to act as the liaison committee.

No favors were asked by the company of the unions but President Ruggeri pledged that the Association would ask physicians to charge only their usual normal fees.

So, you are on trial, doctors! This is an important stage in prepaid medical care, and no abuses will be allowed by your Industrial Health Committee.—From the Utah State Medical Bulletin.

DEAN BOWERS TO LEAVE

Dr. John Z. Bowers, Dean of the University of Utah Medical School, has accepted the post of Dean of the University of Wisconsin Medical School. He will succeed Dean William S. Middleton, who has asked to be relieved of his administrative duties by next July 1. Dr. Bowers, 41, was graduated from the University of Maryland Medical School in 1938, was deputy director of the Division of Biology and Medicine, Atomic Energy Commission, from 1947 to 1950, and has been Dean of the Utah school since then. Dr. Bowers was appointed to his present position as Dean of the University of Utah College of Medicine in February, 1950, when he was doing special work at the radiation laboratories of the University of California at Berkeley, but did not take over his duties until November of that year.

CACHE VALLEY MEETING

Dr. J. Clare Hayward of Logan was chosen President of the Cache Valley Medical Society at their recent meeting. He succeeds Dr. G. S. Francis of Wellsville. The new Vice President is Dr. Merrill C. Daines, while Secretary-Treasurer is Dr. Clair L. Payne, both of Logan. Delegates of the Utah State Medical Association are Dr. Omar S. Budge, Dr. Merrill C. Daines and Dr. C. J. Daines, with alternates being Dr. Francis, Dr. Edwin D. Budge and Dr. E. L. Hanson. Retiring Secretary-Treasurer is Dr. Robert Skabelund of Lewiston.

PROVO FORUM PLANNED

A Health Education Committee has been set up in Provo to activate a series of public meetings featuring panel discussions by prominent physicians. Object of the series will be to inform the public on medical and health questions by having physicians answer questions mailed in by the public. The plan was outlined at a meeting directed by S. R. Boswell, Utah County Agent.

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WITH PNEUMONIA

you have a choice of broad-spectrum

AND OTHER

RESPIRATORY

TRACT INFECTIONS

established by successful use for more than four years in the treatment of pneumonias and other respiratory tract infections due to susceptible organisms:

TERRAMYCIN®

BRAND OF OXYTETRACYCLINE

"The response [of pneumococcal and mixed bacterial pneumonias in which pneumococcus, Staph. aureus hemolyticus, H. influenzae, E. coli and A. aerogenes were isolated from sputum or pharyngeal secretions] was excellent as manifested by improvement of clinical appearance and fall of temperature to normal" within 24 to 48 hours. "A remarkably high number of infants and young children tolerated this drug very well."[1]

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newest of the broad-spectrum antibiotics for the treatment of the pneumonias and other respiratory tract infections due to susceptible organisms:

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"The clinical results in...bacterial pneumonia were generally quite satisfactory" even though most of the patients were over 60 years of age. "Many had serious concomitant diseases such as severe chronic alcoholism, pulmonary emphysema" and other debilitating conditions. "Marked symptomatic improvement occurred in the first 2 or 3 days of therapy with decrease in cough and sputum volume and return of appetite and general sense of well-being."[2]

1. *O'Regan, C., and Schwarzer, S.: J. Pediat. 44:172 (Feb.) 1954.*
2. *Waddington, W. S.; Bergy, G. G.; Nielsen, R. L., and Kirby, W. M. M.: Am. J. M. Sc. 228:164 (Aug.) 1954.*

Pfizer

PFIZER LABORATORIES, *Brooklyn 6, N.Y.*
Division, Chas. Pfizer & Co., Inc.

The Book Corner

New Books Received

New books received are acknowledged in this section. From these, selections will be made for reviews in the interests of the readers. Books here listed will be available for lending from the Denver Medical Library soon after publication.

Synopsis of Obstetrics and Gynecology: By Aleck W. Bourne, M.A., M.B., B.Ch. (Camb.), F.R.C.S. (Eng.), F.R.C.O.G. Published by The Williams & Wilkins Co., Baltimore, Maryland. Eleventh edition. Price. $5.00.

Operative Surgery (Second Edition): By Hamilton Bailey. Dedicated to the memory of Hamilton Bailey, Jr., who was accidentally killed on July 29, 1943, aged 15. Published by Williams & Wilkins Co., Baltimore, Maryland. Price: $6.00.

Emergencies in Medical Practice (Fourth Edition): By C. Allan Birch, M.D., F.R.C.P. 143 illustrations, nine in color. Published by the Williams & Wilkins Co., Baltimore, Maryland. Price: $7.00.

Cultural Difference and Medical Care: By Lyle Saunders, Associate Professor of Preventive Medicine and Public Health (Sociology), University of Colorado, School of Medicine. Published by Russell Sage Foundation, New York. Price: $4.50.

The Auxiliary Heart: By William Walter Wasson, M.D., Consulting Radiologist, St. Anthony Hospital, Children's Hospital, St. Luke's Hospital, National Jewish Hospital, Denver, Colorado. This book is the result of thirty years of intensive study of the chest and the daily attempt to evaluate the lesser circulation as portrayed by the roentgen film. Published by Charles C. Thomas, Springfield, Illinois.

Hugh Roy Cullen: By Ed Kilman and Theon Wright. A story of American opportunity. Published by Prentice-Hall, Inc., New York City. Price: $4.00.

The Role of the Pituitary in Cancer: By Henry K. Wachtel, M.D. The clinical value of pituitary lipid treatment. Published by The William-Frederick Press, New York. Price: $2.00.

The Rate of Appearance, Metabolism and Disappearance of 3,4-Benzpyrene in the Epithelium of Mouse Skin After a Single Application in a Volatile Solvent: A microfluorescence-spectro-analytical study by Gunnar Norden. Printed in Sweden.

Uses of Wine in Medical Practice (A Summary): Published by the Wine Advisory Board, an agricultural industry administrative agency established and operating pursuant to the Marketing Order for Wine, issued and made effective under the authority of the California Marketing Act of 1937.

The Adolescent Exceptional Child: Sponsored by The Woods Schools, a non-profit residential school for exceptional children, Langhorne, Pennsylvania.

Handbook of Medical Treatment (Fourth Edition): Published by the Lange Medical Publications, Los Altos, California. Price: $3.00.

Hypertension, Humoral and Neurogenic Factors: Ciba Foundation Symposium, by Editors of the Ciba Foundation. Published by Little, Brown, & Company, Boston. Price: $6.75.

When Minds Go Wrong: By John Maurice Grimes, M.D. Published by The Devin-Adair Company, 23 East 26th Street, New York 10, N. Y. Price: $3.50.

Review of Medical Microbiology: By Drs. Ernest Jawetz, Joseph L. Melnick, and Edward A. Adelbert. Published by Lange Medical Publications, Los Altos, California. Price: $4.50.

The Skin: By Arthur C. Allen, M.D. 495 full-page illustrations. Published by C. V. Mosby Company. Price: $25.00.

Book Reviews

Review of Physiological Chemistry: By Harold A. Harper, Ph.D. Copyright, 1939, 1944, 1951, 1953. Price, $4.00.

In his preface to the third edition, the author stated that much of the material in this book is drawn from his lectures in basic science to graduate physicians, that it is intended as a supplement to the standard texts of biochemistry, and he expressed the hope that this book would be useful as a review for the physician preparing for State or Specialty Boards.

In the opinion of this reviewer, the book accomplishes well the purpose for which it was designed. It is an elementary and concise survey of the field of medical biochemistry. The print in the present volume is larger than that in the third edition, and its illustrations, charts and tables are well chosen. Typographically and with respect to content the book maintains a high degree of accuracy.

In Chapter 7, Enzymes, the discussion of the mechanism of enzyme action might have been illustrated more specifically by using the work of Dr. E. L. Smith on carboxypeptidase.

The title of this book might better suggest its medical orientation, inasmuch as the unqualified term "physiological chemistry" should refer to the broad science which deals with the chemical processes that go on in living matter. If the title were changed in this way, the book might suggest itself more easily to those for whom it is intended.

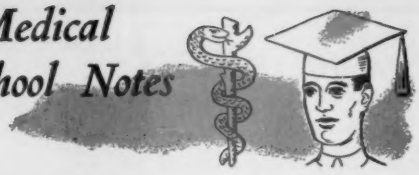
N. BALFOUR SLONIM, M.D., Ph.D.

WANTADS

POSITION WANTED as assistant to General Practitioner for part of year beginning June 30, 1955. Graduate of Temple University Medical School, Philadelphia. Intern at St. Luke's Hospital, Denver. Rural area preferred. Will consider any location in Rocky Mountain area. Reply Box 11, Rocky Mountain Medical Journal.

LOCATION WANTED—Young, married General Practitioner with four years of solo experience desires location in Colorado. Prefer association with small group or one man in Greeley-Loveland or suburban Denver area. Robert G. Ziegler, M.D., Welcome, Minn.

Medical School Notes



FUTURE POSTGRADUATE COURSES
University of Colorado
Medical Center

Medical Technology (for Medical Technicians)—March 16, 17, 18, 19, 1955.
Clinical Management of Emotional Problems in Children—April 4, 5, 6, 7, 8, 9, 1955.
Sixth Annual Colorado Intern and Resident Clinics—June 2, 3, 1955.
Colorado Medical Alumni Clinics—June 10, 1955.
Fundamental Advances in Internal Medicine—June 13, 14, 15, 16, 17, 1955.
Clinical Hematology—July 11, 12, 13, 14, 15, 1955.
Postgraduate Seminar in Ophthalmology—July 25, 26, 27, 28, 1955.
Dermatology for General Practitioners—August 25, 26, 27, 1955.

POSTGRADUATE COURSE

A five-day postgraduate course titled "The Clinical Management of Emotional Problems in Children" has been scheduled for April 4-9, 1955, at the University of Colorado Medical Center. This postgraduate conference has been planned to meet the special interest of physicians who are engaged in the clinical care of children. It will be conducted in an informal manner and registration will be limited in order to keep the group from becoming too large for satisfactory informed discussions.

The guest lecturer will be Dr. Reginald S. Lourie, Director of the Psychiatric Clinic of the Children's Hospital, Washington, D. C. The following subjects will receive consideration, but there will also be opportunities for discussion of other topics based on questions raised during discussion periods:

Difficulties of the Mother-Child Relationship, Before and After Birth; Common Problems in Understanding the One to Two-Year-Old Child; The Mentally Retarded Child—Early Diagnosis and Management; Problems Involved in the Hospitalization of the Pre-School Child; Psychosomatic Disorders of Children; the Conflicts of Adolescence; Some Aspects of Psychiatric Treatment in Children; Professional Consultation for the Child with Serious Emotional Problems; Discussion of the Physician's Role in Adoptions; and Emotional Problems of the Physically Handicapped Child.

Rooms for registrants will be available in a Residence Hall on the Medical Center Campus. A limited number of tuition scholarships have been made available for physicians recently entering practice.

Detailed program and complete information may be obtained by writing to The Office of Postgraduate Medical Education, University of Colorado Medical Center, 4200 East Ninth Avenue, Denver 20, Colorado.

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George Washington University
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C. C. Little, Sc.D.
Director of Jackson Laboratory
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Rochester, Minnesota

Robert D. Moreton, M.D.
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University of Texas, Southwestern Medical School
Dallas, Texas

J. Herbert Nagler, M.D.
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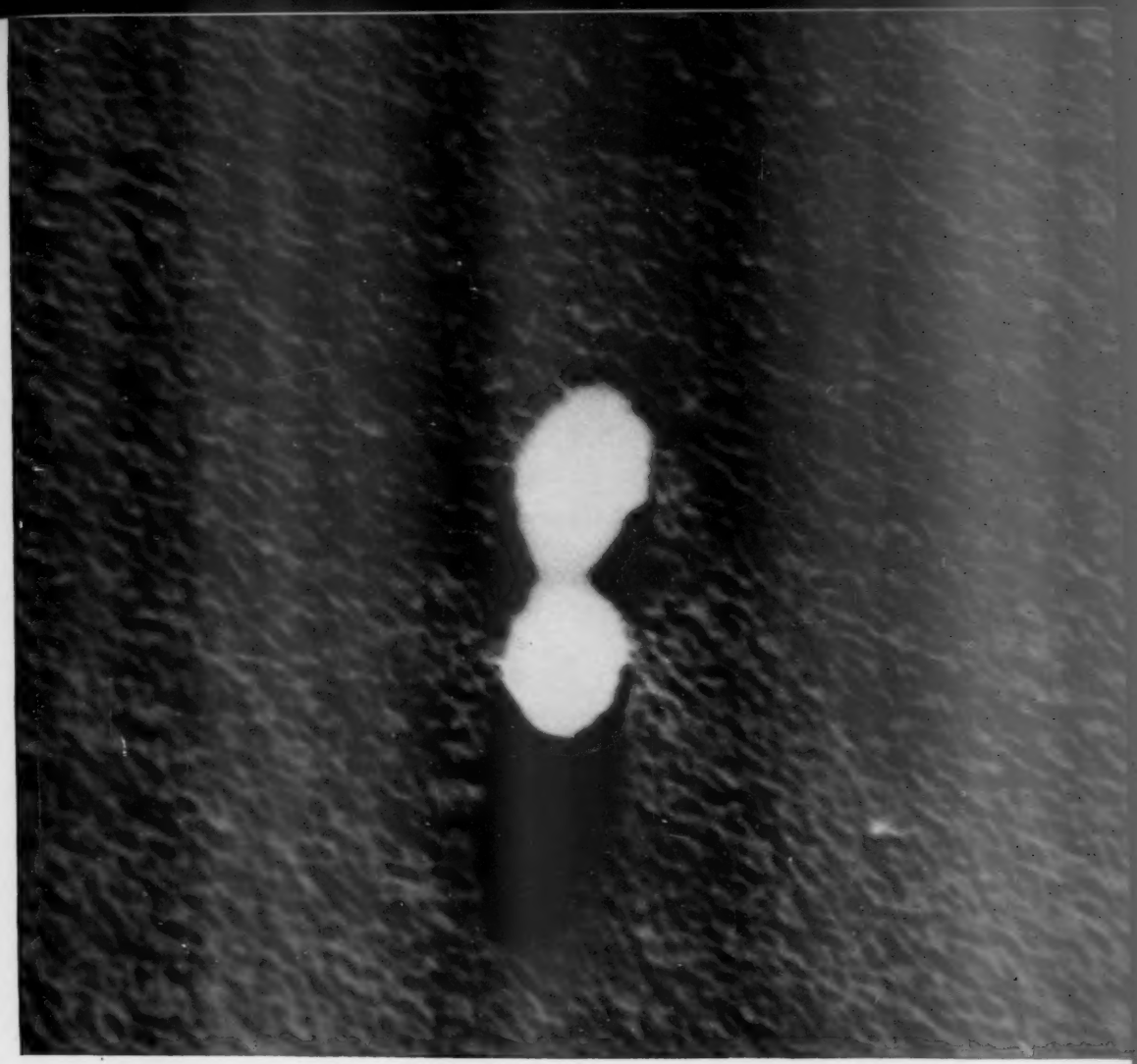

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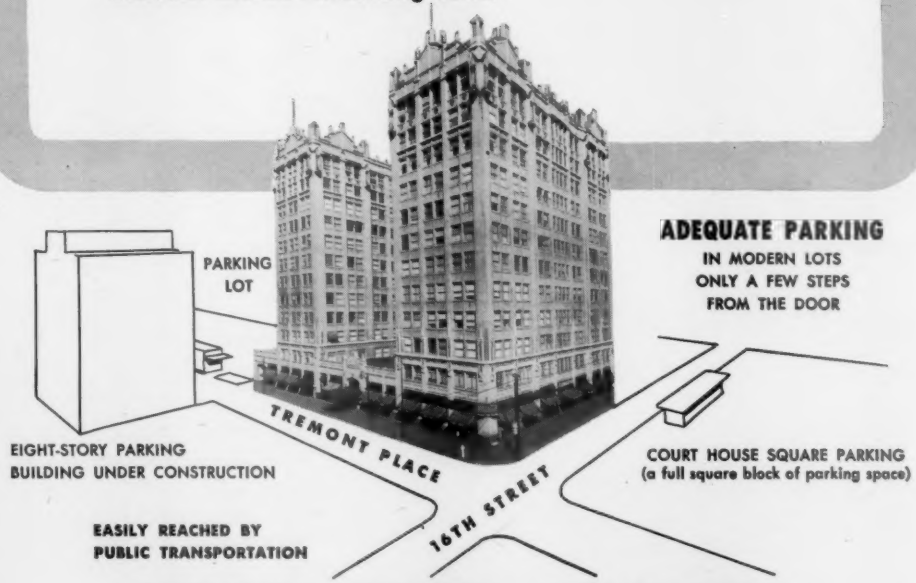

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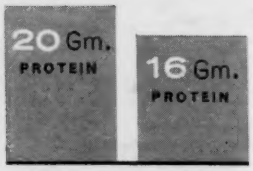

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1. Jeans, P. C., in A.M.A. Handbook of Nutrition, Philadelphia, Blakiston, 1951, pp. 275-298. 2. Stare, F. J., and Davidson, C. S., in The Proteins, American Medical Association, 1945.

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